Indigenous Services Canada
Services aux Autochtones Canada

NON-INSURED HEALTH BENEFITS

First Nations and Inuit Health Branch

DRUG BENEFIT LIST

Winter 2018

The Non-Insured Health Benefits (NIHB) program provides supplementary health benefits, including prescription and non-prescription drugs, for registered First Nations and recognized Inuit throughout Canada.

Visit our Web site at: **www.canada.gc.ca/nihb**

Canada

Department of Indigenous Services Canada
Non-Insured Health Benefits

INTRODUCTION
Drug Benefit List

Effective
Winter 2018

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1. BACKGROUND ON NON-INSURED HEALTH BENEFITS (NIHB) PROGRAM

The Non-Insured Health Benefits (NIHB) Program of the Department of Indigenous Services Canada provides coverage to eligible registered First Nations and recognized Inuit with a limited range of medically necessary health-related goods and services not provided through private or provincial/territorial health insurance plans. These benefits complement provincial and territorial health care programs, such as physician and hospital care, as well as other First Nations and Inuit community-based programs and services. Benefits include drugs, medical transportation, dental care, medical supplies and equipment, crisis intervention counselling and vision care.

The authority for the NIHB Program is based on the 1979 Indian Health Policy which describes the responsibility for the health of First Nations as shared amongst various levels of government, the private sector and First Nations communities. As a result of this shared responsibility, when a benefit is covered under another plan, the federal government requires the coordination of benefits to ensure that the other plan meets its obligations.

2. PURPOSE OF THE NIHB DRUG BENEFIT LIST (DBL)

The Drug Benefit List (DBL) is a listing of the drugs provided as benefits by the NIHB Program. The DBL is updated regularly and published regularly. The listed drugs are those primarily used in a home or ambulatory setting. A prescription from a licensed practitioner is required for any listed drug to be processed as a benefit. Practitioners are health professionals authorized to prescribe drugs within the scope of practice in their province or territory. The DBL is a tool for prescribers and pharmacists that encourages the selection of optimal, cost-effective drug therapy.

3. DRUG REVIEW PROCESS

The review process for drug products that are considered for inclusion as a benefit under the NIHB Program varies depending on the type of drug submitted.

3.1 New Chemical Entities / New Combination Drug Products/ Existing Chemical Entities with New Indication

Submissions for new chemical entities, new combination drug products and existing chemical entities with new indications, must be sent to the Canadian Agency for Drugs and Technologies in Health (CADTH). Clinical and pharmacoeconomic reviews are coordinated by the Common Drug Review (CDR) Directorate, or by the pan-Canadian Oncology Drug Review (pCODR) for cancer therapies, and forwarded to their respective expert committees for recommendations on formulary listing. These recommendations are forwarded to participating drug plans, including the NIHB Program, for consideration. The NIHB Program and other drug plans make listing decisions based on these expert committee recommendations and other specific relevant factors, such as mandate, priorities and resources.

Please refer to CADTH for a list of requirements for manufacturers' submissions and a summary of procedures for the CDR or pCODR process. Inquiries should be directed to:

Canadian Agency for Drugs and Technologies in Health
865 Carling Avenue, Suite 600
Ottawa, Ontario K1S 5S8
Telephone: (613) 226-2553
Website: www.cadth.ca

Please ensure a copy of the complete submission is also sent to NIHB either electronically to NIHB.Drug.Submisions@hc-sc.gc.ca or on compact CD to the mailing address indicated in section 3.2.2.4. Paper (binder) versions of drug submissions are no longer accepted by the NIHB Program.

3.2 Line Extensions, Generics and All Other Submissions

Submissions for line extensions, generics and all other submissions are reviewed internally or by the NIHB Drugs and Therapeutics Advisory Committee (DTAC). Generic drug products are considered for inclusion on the formulary based on provincial interchangeability lists and other relevant factors.

3.2.1 Drugs and Therapeutics Advisory Committee (DTAC)

The DTAC provides formulary listing recommendations for drug products to the NIHB Program. The NIHB Program makes listing decisions based on DTAC recommendations and other specific relevant factors, such as mandate, priorities and resources. The DTAC also contributes to the NIHB Drug Use Evaluation (DUE) Program which promotes safe, therapeutically effective and efficient use of drug therapy for First Nations and Inuit.

The DTAC is an advisory body of highly qualified health professionals who bring impartial and practical expert medical and pharmaceutical advice to the NIHB Program to promote improvement in the health outcomes of First Nations and Inuit clients through effective use of pharmaceuticals. The approach is evidence-based and the advice reflects medical and scientific knowledge, current utilization trends, current clinical practice, health care delivery and specific departmental client healthcare needs.

3.2.2 Submission Requirements

All submissions for drug products that are line extensions, generics and all other types of submissions must be submitted to the NIHB Program. Only drug products with a Health Canada Notice of Compliance (NOC) will be considered for provision as a benefit.

3.2.2.1 Letter of Authorization

The manufacturer will provide a letter authorizing the NIHB Program to gain access to all information with respect to the product in the possession of Health Canada or of the government of any provinces or territory in Canada, Patented Medicine Prices Review Board (PMPRB) or CADTH.

3.2.2.2 Justification for Consideration of Listing

The manufacturer will provide a statement indicating the rationale and evidence to justify the provision of the new product.

3.2.2.3 General Information

Additional information should include:

- Evidence of approval by Health Canada, such as a Notice of Compliance (NOC) and Drug Identification Number (DIN) and
- Two therapeutic Classifications:
  - *American Hospital Formulary Service* (AHFS) Pharmacologic Therapeutic Classification and;
  - The World Health Organization's *Anatomical Therapeutic Chemical* (ATC) Classification

3.2.2.4 Pricing and Marketing Information

The manufacturer must submit current price information for the drug product.

Manufacturers are required to notify the NIHB Program of any significant change to listed drug products. Significant changes include changes in DIN, product name, manufacturer or distributor, indication, product monograph, packaging, formulation, manufacturing specifications or discontinuation of a product. Notification of changes should be provided electronically to the NIHB Program.

All submissions for drug products, to be reviewed for inclusion on the NIHB DBL, must be sent to the NIHB Program electronically. Please send all drug submissions to the following email address: NIHB.Drug.Submissions@hc-sc.gc.ca. Submissions will also be accepted on compact CD when mailed to the following address:

C/o Manager of Policy Development - Pharmacy
Non-Insured Health Benefits
First Nations and Inuit Health Branch,
Department of Indigenous Services Canada
200 Eglantine Driveway, 9th Floor
Postal Locator 1909D Tunney's Pasture

Ottawa, Ontario K1A 0K9

Only ONE copy of the submission is required. Receipt of submission will be acknowledged electronically with a confirmatory email message. Paper (binder) versions of drug submissions are no longer accepted by the NIHB Program.

4. BENEFIT CRITERIA

The following criteria are the framework for the NIHB Program DBL. The criteria provide the basis for decisions about drugs on the formulary relating to:

A. Drug Benefit Listings
B. Deletions
C. Open Benefit
D. Limited Use
E. Exceptions
F. Exclusions

All drugs that are to be either considered for listing or currently listed as Program benefits must, as a minimum:

1. be legally available for sale in Canada with an NOC;

2. be sold in Canada (proof may include a copy of the completed notification form issued under the Food and Drug Regulations or listing on a provincial drug benefit formulary);

3. be administered in a home setting or in other ambulatory care settings;

4. not be provided in a provincially/territorially covered setting (hospital/institution) or provided through provincially/territorial covered programs or clinics according to provincial/territorial legislation; and

5. be in accordance with NIHB Program mandate and policies.

A. Drug Benefit Listings

The NIHB Program, with assistance from the CDR, pCPA, pCODR and the NIHB DTAC, balances a number of factors in making listing decisions about changes to the Drug Benefit List, such as:

- The needs of First Nations and Inuit clients;
- Accumulated scientific and clinical research on currently-listed drugs;
- Cost-benefit analysis;
- Availability of alternatives;
- Current health practices; and
- Policies and listings in provincial drug formularies.

New formulations and new strengths of listed products may be added or may replace previously approved products.

Generic products are added according to provincial/territorial interchangeability lists and other relevant factors.

Combination products are considered for listing if:

1. each component of the combination makes a contribution to the claimed effect;

2. a pharmacological or pharmaceutical rationale exists for the combination;
3. the dosage of each component (amount, frequency, duration) is safe and effective for a significant proportion of the patient population requiring such concurrent therapy as defined in the labeling of the drug; and
4. the cost is reduced, or scientific evidence indicates that the advantages outweigh any additional cost; or
5. an improvement in compliance, resulting in an increase in clinical effectiveness, is demonstrated.

Long Acting (Sustained-Extended Release) Products may be listed when:

1. clinical studies have demonstrated the safety and efficacy of the active ingredient when administered in the long acting form; and
2. a therapeutic advantage is demonstrated in the treatment of the disease entity for which the product is indicated (therapeutic advantage is defined as: improved efficacy relative to the conventional dosage with no increase in toxicity; or less toxicity with improved or similar efficacy); or
3. there is demonstrated improvement in compliance resulting in an increase in clinical effectiveness; or
4. there is evidence that the long acting product is at least as cost-effective as the best price alternative in the conventional form that is currently covered; or
5. there is no suitable conventional dosage form(s) of the drug listed that is readily available.

Injectable Drug Products will be considered if they are:

1. self-administered in a home or other ambulatory setting;
2. not part of a physician's standard office supply;
3. not provided in a provincially/territorially covered hospital or institution; or
4. not provided through provincially/territorial covered programs or clinics according to provincial/territorial legislation.

B. Deletion Criteria

The following deletion criteria guide the removal or delisting of a drug product from the NIHB drug benefit list. Drugs are deleted:

1. when a product is discontinued from the Canadian market;
2. when new products possessing clearly demonstrated therapeutic and safety advantages or improvements have been listed;
3. when new toxicity data shift the risk/benefit ratio to make the continued listing of the product inappropriate;
4. when new information demonstrates that the product does not have the anticipated therapeutic benefit;
5. when the purchase cost is disproportionate to the benefits provided; or

6. when the drug has a high potential for misuse or abuse.

***NOTE:** Drugs may also be removed at the discretion of the Director General, NIHB Program when there are undesirable financial, supply or administrative implications to the continued listing of a product.*

C. Open Benefits

Open benefits are the drugs listed in the NIHB DBL which do not have established criteria or prior approval requirements.

D. Limited Use Benefits

Limited use drugs are drug products listed on the NIHB DBL that may be inappropriate for general listing, but have value in specific circumstances. These products will have specific criteria for provision as a benefit under the NIHB Program. A product will be designated for limited use when:

1. it has the potential for widespread use outside the indications for which benefit has been demonstrated;
2. it has proven effectiveness, but is associated with predictable severe adverse effects;
3. it is usually a second or third line choice for treatment and is required because of allergies, intolerance, treatment failure or noncompliance with a first line alternative; or
4. it is very costly and a therapeutically effective alternative is available as a benefit.

There are three types of limited use benefits:

1. Limited use benefits which do not require prior approval. These include but are not limited to:
    - Multivitamins (which are benefits for children up to six years of age); and
    - Prenatal and postnatal vitamins (which are benefits for women of childbearing age (12 to 50 years).
2. Benefits which have a quantity and/or frequency limit. A maximum quantity of drug is allowed within a specified period of time. No prior approval is required for the recipient to obtain the allowable quantity of drug within the specified period. An example of a category of drugs with a quantity and frequency limit is smoking cessation products. Recipients are eligible to receive up to three treatment courses of nicotine replacement therapy (NRT) within a 12-month period with quantity limits, which include two courses of NRT patches and one course of NRT products used PRN (i.e. gums, lozenges, inhalers).
3. Limited use benefits which require prior approval (using the "Limited Use Drugs Request Form"). Limited use benefits and the criteria for their coverage are identified in the Drug Benefit List and also in Appendix A. The criteria are also listed on the forms faxed to prescribers for completion.

E. Exceptions

Exception drugs are drug products which are not listed in the DBL. These drug products may be approved in special circumstances upon receipt of a completed "Exception Drugs Request Form" from the attending licensed practitioner.

- when the prescription is for a recognized clinical indication and dose which is supported by published evidence or authoritative opinion; and
- when there is significant evidence that the requested drug is superior to drugs already listed as program benefits; or
- when a patient has experienced an adverse reaction with a best-price alternative drug, and a

higher cost alternative is requested by the prescriber; or

- when there is supporting evidence that available alternatives are ineffective, toxic, or contraindicated (personal preference alone does not justify an exception).

F. Exclusions

Exclusions are items not listed as benefits on the DBL and are not available through the exception or appeal processes. These include certain drug therapies for particular conditions which fall outside of the NIHB mandate and are not provided as benefits under the NIHB Program.

Examples of categories of drugs or drug products* that are not considered for coverage under the NIHB Program under any circumstances are listed in Appendix E

- Anti-obesity drugs;
- Household products (e.g. regular soaps and shampoos);
- Cosmetics;
- Alternative therapies, including glucosamine and evening primrose oil;
- Megavitamins;
- Drugs with investigational/experimental status;
- Vaccines
- Medications for travel
- Hair growth stimulants;
- Fertility agents and impotence drugs;
- Selected over-the-counter products;
- Opioid containing cough preparations.

*Note: List of excluded drugs or drug products is not exhaustive and may be modified as necessary

5. POLICIES

A. Best Price Alternative and Interchangeability

The NIHB Program will reimburse only the best price (lowest cost) alternative product in a group of interchangeable drug products. Pharmacists must follow their provincial/territorial pharmacy legislation/policies to identify interchangeable products and to select the lowest-priced brand. (NIHB may not necessarily reimburse at the cost listed in the provincial drug plan formulary).

B. "No Substitution" Claims

NIHB will consider reimbursement for a higher-cost interchangeable product when a patient has experienced an adverse reaction with a lower-cost alternative. In such circumstances, the prescriber must provide the NIHB Program with:

1. a completed and signed Canada Vigilance Adverse Reaction Reporting Form: '*Report of suspected adverse reactions to health products in Canada*' and,

2. the prescription with "*No Substitution*" or "*No Sub*" written by hand or typed on the prescription.

Upon receipt, the pharmacist will forward a copy of the prescription to NIHB for review. The prescriber is responsible for sending a copy of the form to the Canada Vigilance Program. Forms can be obtained by calling the Canada Vigilance Program at 1-866-234-2345 or by downloading a copy from Health Canada website at: ***http://www.hc-sc.gc.ca/dhp-mps/medeff/report-declaration/ar-ei_form-eng.php***

NOTE: The Canada Vigilance Adverse Reaction Reporting Form will not need to be resubmitted for renewals or new prescriptions of the same drug for the patient, although "No Sub" will still have to be written or typed on the prescription.

C. Prescription Quantities

The normal quantity dispensed shall be the entire quantity of the drug prescribed. A maximum 100-day supply should be considered for those circumstances where the patient has been stabilized on a medication and the prescriber feels that further adjustment during the prescribed period is unlikely. Prescriptions for opioids and benzodiazepines have a maximum 30–day supply. The physician may continue to prescribe a smaller quantity with repeats at certain intervals when it is in the patient's best interest.

D. Short Term Dispensing Policy

It is the Program's expectation that certain medications required for long-term maintenance therapy should be prescribed and dispensed in up to 100 days supplies. For refills for medications requiring short-term dispensing for a shorter time than 28 days due to compliance concerns, the Program will only reimburse a total of one dispensing fee per 28 days up to the regional maximum of the Program, These medications include (but are not limited to) the following:

Antihistamines
Antiemetics for cancer chemotherapy (excluding nabilone)
Synthetic antidiuretic hormone
Alpha-adrenoreceptor Antagonists
Anti-Parkinsonian Drugs
Cardiovascular Drugs
Drugs for Treatment of Bone Diseases
Proton Pump Inhibitors
H_2-Receptor Antagonists
Other Drugs for Peptic Ulcer and Gastro-esophageal Reflux Disease (GERD)
Anticoagulants
Respiratory smooth muscle relaxants
Anti-dementia Drugs
Anti-platelet aggregation Drugs
Enzyme Preparations
GI Anti-inflammatory Drugs
Urinary Anti-Spasmotics
OTCs (including vitamins)
Immunosuppressants
Prokinetic agents
Anti-gout Drugs
BPH Drugs
Drugs for Diabetes
Thyroid Therapy
NSAIDs

Note: This list may be amended as required and changes will be communicated through the quarterly on-line updates to the DBL. Medications on the Short term Dispensing list are identified in the DBL using the symbol ST beside the medication strength and dosage form.

The following are exceptions to the STD policy:

- Refills for intermittent treatment of a chronic disorder or refills of a medication which is prescribed to be taken on an "as needed" (PRN) basis. Note: Medications prescribed to be taken on an "as needed" (PRN) basis and dispensed chronically may be subject to audit and recovery.
- Prescriptions for dose changes.
- The following dosage forms: injectable and suppository.
- Refills or new prescriptions when prescribed/dispensed in accordance with a court order.
- Others as identified by the NIHB Program

Compensation

The compensation will be the lesser of the usual and customary fee up to the maximum negotiated NIHB regional dispensing fee for each 28 days supplied. NIHB will continue to audit and recover in instances where quantity reduction occurs.

Less than 28 Day Supply

For the medications listed below in which short-term dispensing is deemed medically necessary, the Program will compensate up to one full dispensing fee every seven days, up to the regional maximum of the Program. If these medications are dispensed daily, the Program will compensate 1/7th of this fee:

Anticonvulsants
Antidepressants
Antipsychotics
Benzodiazepines
Stimulants
Nicotine Replacement Therapy
Hormonal Contraceptives
Needles & Syringes
Drug used in nicotine dependence
Antimanic agents
Estrogens
Progestins

Implementation

When filling a new prescription for a chronic use drug, the Program will pay a full dispensing fee regardless of the days supply. A new prescription may include a dosage change or an intermittent treatment, based on an assessment by a prescriber.

When refilling a prescription for a chronic use drug that is for less than a 28 day supply or when a need for compliance packaging is identified by the prescriber, the Program will pay no more than one full dispensing fee per 28 day period. For the medications listed above the Program will pay no more than full dispensing fee per 7 day period.

A refill is defined as the second and all subsequent fills for a given strength and dosage of a drug.

6. FORMULARY FOR CHRONIC RENAL FAILURE PATIENTS

Clients with chronic renal failure are eligible to receive a list of supplemental benefits that are not included in the NIHB DBL but which are required on a long-term basis. Some supplemental benefits include: darbepoetin alfa products (except in provinces where NIHB clients are eligible to receive darbepoetin alfa through the provincial programs), calcium products, multivitamins formulated for renal patients and select nutritional supplements formulated for renal patients.

New clients requiring drugs on the special formulary will be identified for coverage through the usual prior approval process. Once the client is confirmed as eligible, coverage will automatically be extended to all drugs in the special formulary for as long as needed.

7. PALLIATIVE CARE FORMULARY

Clients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs on the Palliative Care Formulary will generate a Palliative Care Application Form, faxed to the prescriber. Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary for six months if the following criteria are met:

The client:
1. is not receiving care in a provincially covered hospital or provincially covered long-term care facility; and
2. has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less

If coverage is required beyond the initial six months, an additional six months will be granted upon receipt of another completed Palliative Care Application Form.

8. FORMULARY FOR ADJUNCT MEDICATIONS USED DURING ACTIVE CANCER TREATMENTFORMULARY

The NIHB Program has established a new formulary to streamline access to adjunctive (non-chemotherapy) medications frequently used by clients undergoing active cancer treatment.

Clients who are approved for oral chemotherapy drugs are given access to all of the medications in the formulary. Additionally, clients who request, and are approved, for one of the medications on the formulary for a cancer-related indication are also granted access.

Clients are automatically enrolled for a period of six months. If cancer treatment is of a longer duration, access to the formulary will be granted to align with the treatment duration. In the event that treatment duration is not known and the treatment plan extends beyond six months, access to this formulary may be extended upon request.

9. DRUG UTILIZATION EVALUATION

A drug utilization evaluation, which is part of the point-of-service or on-line adjudication system, provides an analysis of both previous claims data and current claims data to identify potential drug-related problems. Messages are returned to pharmacists to alert them of the potential problems. These messages are intended to enhance pharmacy practice with additional information. Currently, the system monitors for:

- potential drug/drug interactions
- duplicate drugs
- duplicate therapy

As part of the NIHB Drug Use Evaluation (DUE) Program, DTAC reviews utilization patterns of medications billed to the NIHB program and provides advice to promote effective, efficient and optimal drug therapy to First Nations and Inuit recipients.

10. GENERAL INFORMATION

Sources of information about the NIHB Program include:

- The NIHB section of the Government of Canada website which provides background information on the Program and a copy of the DBL. This can be found at: www.canada.ca/nihb

Information about the NIHB Program can also be obtained by contacting:

Non-Insured Health Benefits
First Nations and Inuit Health Branch
200 Eglantine Driveway, 9th Floor
Postal Locator 1909D
Tunney's Pasture
Ottawa, Ontario K1A 0K9

11. NIHB PRIVACY CODE

The NIHB Program is committed to protecting an individual's privacy and safeguarding the personal information in its possession. When a benefit request is received, the NIHB Program collects, uses, discloses and retains an individual's personal information according to the applicable federal privacy legislation. The information collected is limited to only that information required for the NIHB Program to administer and verify benefits.

As a program of the federal government, the NIHB Program must comply with the Privacy Act, the Canadian Charter of Rights and Freedoms, the Access to Information Act, the Treasury Board of Canada Privacy and Data Protection Policies, the Government Security Policy, and Health Canada's Security Policy.

12. PHARMACOLOGIC-THERAPEUTIC CLASSIFICATION OF DRUGS

The drugs in the NIHB DBL are classified according to the *AHFS* Pharmacologic-Therapeutic classification developed by the American Society of Health-System Pharmacists for the purposes of the *AHFS Drug Information.*

Permission to use this system has been granted by the American Society of Health-System Pharmacists. The Society is not responsible for the accuracy of transpositions from the original context.

Drugs are listed alphabetically within each therapeutic classification according to their chemical names. Under each drug, acceptable products are listed.

LEGEND

1. Pharmacologic-Therapeutic classification
2. Pharmacologic-Therapeutic sub-classification
3. Nonproprietary or generic name of the drug
4. Drug strength and dosage form. ST indicates the drug is identified as a chronic medication under the Short-Term Dispensing Policy.
5. Drug Identification Number (DIN), assigned by the Therapeutic Products Directorate of Health Canada, to uniquely identify the drug product as to its manufacturer, name and strength of active ingredients, route of administration and pharmaceutical dosage form
6. Brand name of the drug
7. List of all active ingredients in a combination product
8. Strengths of active ingredients in a combination product, listed in the same order as the ingredients
9. List of available brands of drugs. Provincial or territorial drug plan formularies should be consulted to determine interchangeable products and to identify best price (lowest cost) alternatives
10. Three letter identification code assigned to manufacturer

1 → **04:00 ANTIHISTAMINE DRUGS**

2 → **04.00.00 ANTIHISTAMINE DRUGS**

3 → **CETIRIZINE HCL**

4 → ST 10mg Tablet

5 → 02231603 APO-CETIRIZINE APX

6

7 → **28:08.08 ACETAMINOPHEN, CAFFEINE, CODEINE PHOSPHATE**

8 → 300mg & 15mg & 15mg Tablet

00706515	PMS-ACET 2	PMS
00653241	RATIO-LENOLTEC NO.2	RPH
02163934	TYLENOL WITH CODEINE NO.2	JNO

9

300mg & 15mg & 30mg Tablet

00653276	RATIO-LENOLTEC NO.3	RPH
02163926	TYLENOL WITH CODEINE NO.3	JNO

10

DRUG BENEFIT LIST

04:00 ANTIHISTAMINE DRUGS

04:04.04 ANTIHISTAMINE DRUGS

DIPHENHYDRAMINE HYDROCHLORIDE

ST **25MG CAPSULE**

00757683	PDP-DIPHENHYDRAMINE	PMS

ST **50MG CAPSULE**

00757691	PDP-DIPHENHYDRAMINE	PMS

ST **2.5MG/ML ELIXIR**

00833266	ALLERGY ELIXIR	TAN
00804193	ALLERNIX ELIXIR	TEV
02019736	BENADRYL	MCL
00792705	PMS-DIPHENHYDRAMINE	PMS

ST **12.5MG/5ML ELIXIR**

02298503	DIPHENHYDRAMINE	JMP

ST **1.25MG/ML LIQUID**

02019698	BENADRYL CHILDRENS	MCL

50MG/ML LIQUID

00596612	DIPHENHYDRAMINE	SDZ
02219336	DIPHENIST	OMG
00878200	PMS-DIPHENHYDRAMINE	PMS

ST **25MG TABLET**

02176483	ALLER-AIDE	TEV
01949454	ALLERGY	TAN
02229492	ALLERGY FORMULA	VTH
02097583	ALLERNIX	TEV
02017849	BENADRYL	MCL
02257548	DIPHENHYDRAMINE	JMP
02239029	NADRYL	RIV

ST **50MG TABLET**

02230398	ALLERGY EXTRA STRENGTH	TAN
02097575	ALLERNIX EXTRA STRENGTH	TEV
02257556	DIPHENHYDRAMINE	JMP

04:04.20 ANTIHISTAMINE DRUGS

CHLORPHENIRAMINE MALEATE

ST **4MG TABLET**

00738972	CHLOR-TRIPOLON	BAY
00021288	NOVO-PHENIRAM	TEV

ST **12MG TABLET (EXTENDED RELEASE)**

00738964	CHLOR-TRIPOLON	BAY

04:08.00 ANTIHISTAMINE DRUGS

CETIRIZINE HYDROCHLORIDE

ST **1MG/ML SYRUP**

02238337	REACTINE	MCL

ST **10MG TABLET**

02315955	ALLERGY RELIEF	PMS
02231603	APO-CETIRIZINE	APX
02375095	CETIRIZINE	APX
02451778	JAMP-CETIRIZINE	JMP
02427133	MAR-CETIRIZINE	MAR
02223554	REACTINE	MCL

ST **20MG TABLET**

02453363	APO-CETIRIZINE	APX
02450526	CETIRIZINE	PDL
02427141	MAR-CETIRIZINE	MAR

04:08.00 ANTIHISTAMINE DRUGS

CETIRIZINE HYDROCHLORIDE

ST **20MG TABLET**

02315963	PMS-CETIRIZINE	PMS
02427192	PRIVA-CETIRIZINE	PHA
01900978	REACTINE	MCL

DESLORATADINE

ST **0.5MG/ML SYRUP**

02247193	AERIUS KIDS	BAY

ST **5MG TABLET**

02243919	AERIUS	BAY
02369656	ALLERNIX MULTI SYMPTOM	TEV
02338424	DESLORATADINE	APX
02298155	DESLORATADINE ALLERGY CONTROL	PMS

FEXOFENADINE HYDROCHLORIDE

ST **60MG TABLET**

02231462	ALLEGRA 12 HOUR	SAC

ST **120MG TABLET**

02242819	ALLEGRA 24 HOUR	SAC

LORATADINE

ST **1MG/ML SYRUP**

02241523	CLARITIN KIDS	BAY

ST **10MG TABLET**

02280159	24 HOUR ALLERGY REMEDY	VTH
02418959	ALLERTIN	APX
02243880	APO-LORATADINE	APX
00782696	CLARITIN	BAY
02366444	LORATADINE	APX

04:92.00 ANTIHISTAMINE DRUGS

KETOTIFEN FUMARATE

ST **0.2MG/ML SYRUP**

00600784	ZADITEN	TEV

ST **1MG TABLET**

00577308	ZADITEN	TEV

08:00 ANTI-INFECTIVE AGENTS

08:08.00 ANTHELMINTICS

MEBENDAZOLE

100MG TABLET

00556734	VERMOX	JSO

PYRANTEL PAMOATE

50MG/ML SUSPENSION

01944355	COMBANTRIN	MCL

125MG TABLET

01944363	COMBANTRIN	MCL

08:12.02 AMINOGLYCOSIDES

AMIKACIN SULFATE

Limited use benefit (prior approval required).

250MG LIQUID

02242971	AMIKACIN SULFATE	SDZ

GENTAMICIN SULFATE

1MG/ML SOLUTION

02082136	GENTAMICIN IV	BAX

1.4MG/ML SOLUTION

01913530	GENTAMICIN SULFATE IN SODIUM CHLORIDE	HOS

1.6MG/ML SOLUTION

02082152	GENTAMICIN IV	BAX

10MG/ML SOLUTION

02268531	GENTAMICIN	SDZ

40MG/ML SOLUTION

02225131	CIDOMYCIN	UNK
02242652	GENTAMICIN	SDZ

PDIN FOR EXTEMPORANEOUS MIXTURE

99506004	GENTAMYCIN STERILE INFUSION	UNK

TOBRAMYCIN

Limited use benefit (prior approval required).

1.2G POWDER FOR SOLUTION

00533688	TOBRAMYCIN	FKD
02285150	TOBRAMYCIN	RAX

10MG/ML SOLUTION

02230639	TOBRAMYCIN	FKD
02241209	TOBRAMYCIN	SDZ

40MG/ML SOLUTION

02420287	JAMP-TOBRAMYCIN	JMP
02230640	TOBRAMYCIN	FKD
02241210	TOBRAMYCIN	SDZ
02382814	TOBRAMYCIN	MYL
99005069	TOBRAMYCINE	UNK

08:12.06 CEPHALOSPORINS

CEFACLOR

250MG CAPSULE

02230263	APO-CEFACLOR	APX
02237729	CEFACLOR	IVX

500MG CAPSULE

02230264	APO-CEFACLOR	APX
02237730	CEFACLOR	IVX

08:12.06 CEPHALOSPORINS

CEFACLOR

75MG/ML POWDER

02237502	APO-CEFACLOR	APX

CEFADROXIL

500MG CAPSULE

02240774	APO-CEFADROXIL	APX
02311062	PRO-CEFADROXIL	PDL
02235134	TEVA-CEFADROXIL	TEV

CEFAZOLIN SODIUM

500MG POWDER FOR SOLUTION

02108119	CEFAZOLIN	TEV
02237137	CEFAZOLIN	FKD
02308932	CEFAZOLIN	SDZ

1G POWDER FOR SOLUTION

02108127	CEFAZOLIN	TEV
02237138	CEFAZOLIN	FKD
02297205	CEFAZOLIN	HOS
02308959	CEFAZOLIN	SDZ
02437112	CEFAZOLIN	RAX

10G POWDER FOR SOLUTION

02108135	CEFAZOLIN	TEV
02237140	CEFAZOLIN	FKD
02297213	CEFAZOLIN	HOS
02308967	CEFAZOLIN	SDZ
02437120	CEFAZOLIN	RAX

PDIN FOR EXTEMPORANEOUS MIXTURE

99506000	CEFAZOLIN STERILE INFUSION	UNK

CEFIXIME

20MG/ML POWDER FOR SUSPENSION

00868965	SUPRAX	ODN

400MG TABLET

02432773	AURO-CEFIXIME	AUR
00868981	SUPRAX	ODN

CEFPROZIL

25MG/ML POWDER FOR SUSPENSION

02293943	APO-CEFPROZIL	APX
02163675	CEFZIL	BMS
02329204	RAN-CEFPROZIL	RBY
02303426	SANDOZ CEFPROZIL	SDZ

50MG/ML POWDER FOR SUSPENSION

02293951	APO-CEFPROZIL	APX
02293579	RAN-CEFPROZIL	RBY
02303434	SANDOZ CEFPROZIL	SDZ

250MG TABLET

02292998	APO-CEFPROZIL	APX
02347245	AURO-CEFPROZIL	AUR
02293528	RAN-CEFPROZIL	RBY
02302179	SANDOZ CEFPROZIL	SDZ

500MG TABLET

02293005	APO-CEFPROZIL	APX
02347253	AURO-CEFPROZIL	AUR
02293536	RAN-CEFPROZIL	RBY
02302187	SANDOZ CEFPROZIL	SDZ

08:12.06 CEPHALOSPORINS

CEFTAZIDIME

Limited use benefit (prior approval required).

1G POWDER FOR SOLUTION

00886971	CEFTAZIDIME	FKD
02437848	CEFTAZIDIME	RAX
02212218	FORTAZ 1G	GSK

2G POWDER FOR SOLUTION

00886955	CEFTAZIDIME	FKD
02437856	CEFTAZIDIME	RAX
02212226	FORTAZ 2G	GSK

3G POWDER FOR SOLUTION

02439522	CEFTAZIDIME	RAX

6G POWDER FOR SOLUTION

00886963	CEFTAZIDIME	FKD
02437864	CEFTAZIDIME	RAX
02212234	FORTAZ 6G	GSK

CEFTRIAXONE SODIUM

250MG POWDER FOR SOLUTION

02250276	CEFTRIAXONE	HOS
02289679	CEFTRIAXONE	FKD
02292262	CEFTRIAXONE	SDZ
02292866	CEFTRIAXONE	HOS
02325594	CEFTRIAXONE	RAX

1G POWDER FOR SOLUTION

02250292	CEFTRIAXONE	HOS
02287633	CEFTRIAXONE	TEV
02292270	CEFTRIAXONE	SDZ
02292874	CEFTRIAXONE	HOS
02325616	CEFTRIAXONE	RAX

2G POWDER FOR SOLUTION

02250306	CEFTRIAXONE	HOS
02292289	CEFTRIAXONE	SDZ
02292882	CEFTRIAXONE	HOS
02325624	CEFTRIAXONE	RAX

10G POWDER FOR SOLUTION

02325632	CEFTRIAXONE SODIUM FOR BP	RAX

PDIN FOR EXTEMPORANEOUS MIXTURE

99506001	CEFTRIAXONE STERILE INFUSION	UNK

CEFUROXIME AXETIL

25MG/ML POWDER FOR SOLUTION

02212307	CEFTIN	GSK

250MG TABLET

02244393	APO-CEFUROXIME	APX
02344823	AURO-CEFUROXIME	APL
02212277	CEFTIN	GSK
02242656	RATIO-CEFUROXIME	TEV

500MG TABLET

02244394	APO-CEFUROXIME	APX
02344831	AURO-CEFUROXIME	APL
02212285	CEFTIN	GSK
02311453	PRO-CEFUROXIM	PDL
02242657	RATIO-CEFUROXIME	TEV

08:12.06 CEPHALOSPORINS

CEPHALEXIN

250MG CAPSULE

00342084	TEVA-CEPHALEXIN	TEV

500MG CAPSULE

00342114	TEVA-CEPHALEXIN	TEV

25MG/ML POWDER FOR SUSPENSION

02177862	DOM-CEPHALEXIN	DPC
00015547	KEFLEX	PED
00342106	TEVA-CEPHALEXIN	TEV

50MG/ML POWDER FOR SUSPENSION

02177870	DOM-CEPHALEXIN	DPC
00035645	KEFLEX	PED
00342092	TEVA-CEPHALEXIN	TEV

250MG TABLET

00768723	APO-CEPHALEX	APX
02177846	DOM-CEPHALEXIN	DPC
00403628	KEFLEX	PED
02177781	PMS-CEPHALEXIN	PMS
00583413	TEVA-CEPHALEXIN	TEV

500MG TABLET

00768715	APO-CEPHALEX	APX
00828866	CEPHALEXIN	PDL
02177854	DOM-CEPHALEXIN	DPC
00244392	KEFLEX	PED
02177803	PMS-CEPHALEXIN	PMS
00583421	TEVA-CEPHALEXIN	TEV

08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS

ERTAPENEM

Limited use benefit (prior approval required).

1G POWDER FOR SOLUTION

02247437	INVANZ	FRS

MEROPENEM

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

02378787	MEROPENEM	SDZ
02218488	MERREM	AZC

1G POWDER FOR SOLUTION

02378795	MEROPENEM	SDZ
02436507	MEROPENEM	RAX
02218496	MERREM	AZC

08:12.12 MACROLIDES

AZITHROMYCIN

20MG/ML POWDER FOR SUSPENSION

02274566	GD-AZITHROMYCIN	PFI
02418452	PMS-AZITHROMYCIN	PMS
02332388	SANDOZ AZITHROMYCIN	SDZ
02223716	ZITHROMAX	PFI

40MG/ML POWDER FOR SUSPENSION

02274574	GD-AZITHROMYCIN	PFI
02418460	PMS-AZITHROMYCIN	PMS
02332396	SANDOZ AZITHROMYCIN	SDZ
02223724	ZITHROMAX	PFI

08:12.12 MACROLIDES

AZITHROMYCIN

250MG TABLET

02255340	ACT AZITHROMYCIN	ACG
02247423	APO-AZITHROMYCIN	APX
02415542	APO-AZITHROMYCIN	APX
02330881	AZITHROMYCIN	SAN
02442434	AZITHROMYCIN	SIV
02278499	DOM-AZITHROMYCIN	DPC
02274531	GD-AZITHROMYCIN	PFI
02452308	JAMP-AZITHROMYCIN	JMP
02452324	MAR-AZITHROMYCIN	MAR
02278359	MYLAN-AZITHROMYCIN	MYL
02261634	PMS-AZITHROMYCIN	PMS
02310600	PRO-AZITHROMYCINE	PDL
02275309	RIVA-AZITHROMYCIN	RIV
02265826	SANDOZ AZITHROMYCIN	SDZ
02267845	TEVA-AZITHROMYCIN	TEV
02212021	ZITHROMAX	PFI

600MG TABLET

02256088	ACT AZITHROMYCIN	ACG
02261642	PMS-AZITHROMYCIN	PMS
02231143	ZITHROMAX	PFI

CLARITHROMYCIN

25MG/ML GRANULES FOR SUSPENSION

02146908	BIAXIN	BGP
02408988	CLARITHROMYCIN	SAN
02390442	TARO-CLARITHROMYCIN	TAR

50MG/ML GRANULES FOR SUSPENSION

02244641	BIAXIN	BGP
02408996	CLARITHROMYCIN	SAN
02390450	TARO-CLARITHROMYCIN	TAR

250MG TABLET

02274744	APO-CLARITHROMYCIN	APX
01984853	BIAXIN	BGP
02324482	CLARITHROMYCIN	PDL
02442469	CLARITHROMYCIN	SIV
02247573	PMS-CLARITHROMYCIN	PMS
02361426	RAN-CLARITHROMYCIN	RBY
02266539	SANDOZ CLARITHROMYCIN	SDZ
02248804	TEVA-CLARITHROMYCIN	TEV

500MG TABLET

02274752	APO-CLARITHROMYCIN	APX
02126710	BIAXIN	BGP
02324490	CLARITHROMYCIN	PDL
02442485	CLARITHROMYCIN	SIV
02351005	DOM-CLARITHROMYCIN	DPC
02247574	PMS-CLARITHROMYCIN	PMS
02361434	RAN-CLARITHROMYCIN	RBY
02346532	RIVA-CLARITHROMYCIN	RIV
02266547	SANDOZ CLARITHROMYCIN	SDZ
02248805	TEVA-CLARITHROMYCIN	TEV

500MG TABLET (EXTENDED RELEASE)

02403196	ACT CLARITHROMYCIN XL	ACG
02413345	APO-CLARITHROMYCIN XL	APX
02244756	BIAXIN XL	BGP

08:12.12 MACROLIDES

ERYTHROMYCIN

250MG CAPSULE (ENTERIC COATED)

00607142	ERYC	PFI

333MG CAPSULE (ENTERIC COATED)

00873454	ERYC	PFI

250MG TABLET

00682020	ERYTHRO BASE	AAP

ERYTHROMYCIN ESTOLATE

50MG/ML SUSPENSION

00262595	NOVO-RYTHRO ESTOLATE	TEV

ERYTHROMYCIN ETHYLSUCCINATE

600MG TABLET

00637416	ERYTHRO-ES	AAP

ERYTHROMYCIN STEARATE

250MG TABLET

00545678	ERYTHRO-S	AAP

500MG TABLET

00688568	ERYTHRO-S	AAP

08:12.16 PENICILLINS

AMOXICILLIN

250MG CAPSULE

02352710	AMOXICILLIN	SAN
02401495	AMOXICILLIN	SIV
00628115	APO-AMOXI	APX
02388073	AURO-AMOXICILLIN	AUR
02433060	JAMP-AMOXICILLIN	JMP
02238171	MYLAN-AMOXICILLIN	MYL
00406724	NOVAMOXIN	TEV
02230243	PMS-AMOXICILLIN	PMS

500MG CAPSULE

02352729	AMOXICILLIN	SAN
02401509	AMOXICILLIN	SIV
00628123	APO-AMOXI	APX
02388081	AURO-AMOXICILLIN	AUR
02433079	JAMP-AMOXICILLIN	JMP
02238172	MYLAN-AMOXICILLIN	MYL
00406716	NOVAMOXIN	TEV
02230244	PMS-AMOXICILLIN	PMS
00644315	PRO AMOX	PDL

25MG/ML GRANULES FOR SUSPENSION

00452149	NOVAMOXIN	TEV
01934171	NOVAMOXIN	TEV

50MG/ML GRANULES FOR SUSPENSION

02352753	AMOXICILLIN	SAN
02401541	AMOXICILLIN	SIV
02352788	AMOXICILLIN (SUGAR REDUCED)	SAN
00452130	NOVAMOXIN	TEV
01934163	NOVAMOXIN	TEV

25MG/ML POWDER FOR SUSPENSION

00628131	APO-AMOXI	APX
02230245	PMS-AMOXICILLIN	PMS

50MG/ML POWDER FOR SUSPENSION

00628158	APO-AMOXI	APX

08:12.16 PENICILLINS

AMOXICILLIN

50MG/ML POWDER FOR SUSPENSION

02230880	APO-AMOXI SUGAR FREE	APX
02230246	PMS-AMOXICILLIN	PMS
00644331	PRO-AMOX	PDL

125MG TABLET (CHEWABLE)

02036347	NOVAMOXIN	TEV

250MG TABLET (CHEWABLE)

02036355	NOVAMOXIN	TEV

AMOXICILLIN, CLAVULANIC ACID

25MG & 6.25MG/ML POWDER FOR SUSPENSION

02243986	APO-AMOXI CLAV	APX
01916882	CLAVULIN 125 F	GSK
02244646	RATIO-ACLAVULANATE	TEV

40MG & 5.7MG/ML POWDER FOR SUSPENSION

02288559	APO-AMOXI CLAV	APX
02238831	CLAVULIN 200	GSK

50MG & 12.5MG/ML POWDER FOR SUSPENSION

02243987	APO-AMOXI CLAV	APX
01916874	CLAVULIN 250 F	GSK

80MG & 11.4MG/ML POWDER FOR SUSPENSION

02238830	CLAVULIN 400	GSK

250MG & 125MG TABLET

02243350	APO-AMOXI CLAV	APX

500MG & 125MG TABLET

02326515	AMOXI-CLAV	PDL
02243351	APO-AMOXI CLAV	APX
01916858	CLAVULIN 500 F	GSK
02243771	RATIO-ACLAVULANATE	TEV

875MG & 125MG TABLET

02326523	AMOXI-CLAV	PDL
02245623	APO-AMOXI CLAV	APX
02238829	CLAVULIN 875	GSK
02247021	RATIO-ACLAVULANATE	TEV

AMPICILLIN

250MG CAPSULE

00020877	TEVA-AMPICILLIN	TEV

500MG CAPSULE

00020885	TEVA-AMPICILLIN	TEV

50MG/ML LIQUID

00603287	APO AMPI	APX

1G POWDER FOR SOLUTION

01933345	AMPICILLIN SODIUM	TEV

2G POWDER FOR SOLUTION

01933353	AMPICILLIN SODIUM	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99506005	AMPICILLIN STERILE INFUSION	UNK

CLOXACILLIN SODIUM

250MG CAPSULE

00337765	TEVA-CLOXACILLIN	TEV

500MG CAPSULE

00337773	TEVA-CLOXACILLIN	TEV

25MG/ML GRANULES FOR SOLUTION

00337757	TEVA-CLOXACILLIN	TEV

08:12.16 PENICILLINS

PENICILLIN G BENZATHINE

600,000U/ML SUSPENSION

02291924	BICILLIN	PFI

PENICILLIN G POTASSIUM

1MU INJECTION

00773727	NOVO-PENICILLIN G POTASSIUM	NOP

PENICILLIN G SODIUM

1MU POWDER FOR SOLUTION

01930672	PENICILLIN G	TEV

5MU POWDER FOR SOLUTION

00883751	PENICILLIN G	TEV

10MU POWDER FOR SOLUTION

01930680	PENICILLIN G	TEV
02220296	PENICILLIN G	FKD

1000000U POWDER FOR SOLUTION

02220261	PENICILLIN G SODIUM	FKD

5000000U POWDER FOR SOLUTION

02060094	CRYSTAPEN	MYL
02220288	PENICILLIN G SODIUM	FKD

PDIN FOR EXTEMPORANEOUS MIXTURE

99506003	PENICILLIN G STERILE INFUSION	UNK

PENICILLIN V POTASSIUM

25MG/ML POWDER FOR SOLUTION

00642223	APO PEN VK	APX

60MG/ML POWDER FOR SOLUTION

00642231	APO PEN VK	APX
00391603	NOVO-PEN VK	NOP

300MG TABLET

00642215	PEN-VK	AAP

PIPERACILLIN, TAZOBACTAM

Limited use benefit (prior approval required).

2G & 0.25G POWDER FOR SOLUTION

02299623	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02370158	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

3G & 0.375G POWDER FOR SOLUTION

02299631	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308452	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362627	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370166	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

4G & 0.5G POWDER FOR SOLUTION

02299658	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308460	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362635	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370174	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

08:12.16 PENICILLINS

PIPERACILLIN, TAZOBACTAM

Limited use benefit (prior approval required).

12G & 1.5G POWDER FOR SOLUTION

02330547	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02377748	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX

36G & 4.5G POWDER FOR SOLUTION

02439131	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX

08:12.18 QUINOLONES

CIPROFLOXACIN HYDROCHLORIDE

100MG/ML SUSPENSION

02237514	CIPRO	BAY

250MG TABLET

02247339	ACT CIPROFLOXACIN	TEV
02229521	APO-CIPROFLOX	APX
02381907	AURO-CIPROFLOXACIN	AUR
02155958	CIPRO	BAY
02353318	CIPROFLOXACIN	SAN
02386119	CIPROFLOXACIN	SIV
02380358	JAMP-CIPROFLOXACIN	JMP
02379686	MAR-CIPROFLOXACIN	MAR
02423553	MINT-CIPROFLOX	MIN
02317427	MINT-CIPROFLOXACIN	MIN
02245647	MYLAN-CIPROFLOXACIN	MYL
02248437	PMS-CIPROFLOXACIN	PMS
02317796	PRO-CIPROFLOXACIN	PDL
02303728	RAN-CIPROFLOX	RBY
02246825	RATIO-CIPROFLOXACIN	TEV
02251221	RIVA-CIPROFLOXACIN	RIV
02248756	SANDOZ CIPROFLOXACIN	SDZ
02379627	SEPTA-CIPROFLOXACIN	SPT
02266962	TARO-CIPROFLOXACIN	TAR
02161737	TEVA-CIPROFLOXACIN	TEV

500MG TABLET

02247340	ACT CIPROFLOXACIN	TEV
02229522	APO-CIPROFLOX	APX
02381923	AURO-CIPROFLOXACIN	AUR
02155966	CIPRO	BAY
02353326	CIPROFLOXACIN	SAN
02386127	CIPROFLOXACIN	SIV
02251280	DOM-CIPROFLOXACIN	DPC
02380366	JAMP-CIPROFLOXACIN	JMP
02379694	MAR-CIPROFLOXACIN	MAR
02423561	MINT-CIPROFLOX	MIN
02317435	MINT-CIPROFLOXACIN	MIN
02245648	MYLAN-CIPROFLOXACIN	MYL
02248438	PMS-CIPROFLOXACIN	PMS
02317818	PRO-CIPROFLOXACIN	PDL
02303736	RAN-CIPROFLOX	RBY
02246826	RATIO-CIPROFLOXACIN	TEV
02251248	RIVA-CIPROFLOXACIN	RIV
02248757	SANDOZ CIPROFLOXACIN	SDZ
02379635	SEPTA-CIPROFLOXACIN	SPT
02266970	TARO-CIPROFLOXACIN	TAR

08:12.18 QUINOLONES

CIPROFLOXACIN HYDROCHLORIDE

500MG TABLET

02161745	TEVA-CIPROFLOXACIN	TEV

750MG TABLET

02247341	ACT CIPROFLOXACIN	TEV
02229523	APO-CIPROFLOX	APX
02381931	AURO-CIPROFLOXACIN	AUR
02155974	CIPRO	BAY
02380374	JAMP-CIPROFLOXACIN	JMP
02379708	MAR-CIPROFLOXACIN	MAR
02423588	MINT-CIPROFLOX	MIN
02317443	MINT-CIPROFLOXACIN	MIN
02245649	MYLAN-CIPROFLOXACIN	MYL
02248439	PMS-CIPROFLOXACIN	PMS
02303744	RAN-CIPROFLOX	RBY
02246827	RATIO-CIPROFLOXACIN	TEV
02251256	RIVA-CIPROFLOXACIN	RIV
02248758	SANDOZ CIPROFLOXACIN	SDZ
02379643	SEPTA-CIPROFLOXACIN	SPT
02161753	TEVA-CIPROFLOXACIN	TEV

LEVOFLOXACIN HEMIHYDRATE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

250MG TABLET

02315424	ACT LEVOFLOXACIN	TEV
02284707	APO-LEVOFLOXACIN	APX
02284677	PMS-LEVOFLOXACIN	PMS
02298635	SANDOZ LEVOFLOXACIN	SDZ
02248262	TEVA-LEVOFLOXACIN	TEV

500MG TABLET

02315432	ACT LEVOFLOXACIN	TEV
02284715	APO-LEVOFLOXACIN	APX
02415879	LEVOFLOXACIN	PDL
02284685	PMS-LEVOFLOXACIN	PMS
02298643	SANDOZ LEVOFLOXACIN	SDZ
02248263	TEVA-LEVOFLOXACIN	TEV

750MG TABLET

02315440	ACT LEVOFLOXACIN	TEV
02325942	APO-LEVOFLOXACIN	APX
02305585	PMS-LEVOFLOXACIN	PMS
02298651	SANDOZ LEVOFLOXACIN	SDZ
02285649	TEVA-LEVOFLOXACIN	TEV

MOXIFLOXACIN HYDROCHLORIDE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

400MG TABLET

02404923	APO-MOXIFLOXACIN	APX
02432242	AURO-MOXIFLOXACIN	AUR
02242965	AVELOX	BAY
02443929	JAMP-MOXIFLOXACIN	JMP
02447061	JAMP-MOXIFLOXACIN	JMP
02447053	MAR-MOXIFLOXACIN	MAR

08:12.18 QUINOLONES

MOXIFLOXACIN HYDROCHLORIDE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

400MG TABLET

02457814	MED-MOXIFLOXACIN	GMP
02462974	MOXIFLOXACIN	PDL
02450976	RIVA-MOXIFLOXACIN	RIV
02383381	SANDOZ MOXIFLOXACIN	SDZ
02375702	TEVA-MOXIFLOXACIN	TEV

NORFLOXACIN

400MG TABLET

02229524	APO-NORFLOX	APX
02269627	CO NORFLOXACIN	OBT
02237682	TEVA-NORFLOXACIN	TEV

08:12.20 SULFONAMIDES

SULFAMETHOXAZOLE

500MG TABLET

00421480	APO SULFAMETHOXAZOLE	APX

SULFAMETHOXAZOLE, TRIMETHOPRIM

40MG & 8MG/ML SUSPENSION

00726540	TEVA-TRIMEL	TEV

100MG & 20MG TABLET

00445266	APO SULFATRIM PEDIATRIC	APX

400MG & 80MG TABLET

00445274	APO SULFATRIM	APX
00510637	TEVA-TRIMEL	TEV

800MG & 160MG TABLET

00445282	APO SULFATRIM DS	APX
00512524	PROTRIN DF	PDL
00510645	TEVA-TRIMEL DS	TEV

SULFASALAZINE

500MG TABLET

00598461	PMS-SULFASALAZINE	PMS
02064480	SALAZOPYRIN	PFI

500MG TABLET (ENTERIC COATED)

00598488	PMS-SULFASALAZINE	PMS
02064472	SALAZOPYRIN EN	PFI

08:12.24 TETRACYCLINES

DOXYCYCLINE HYCLATE

100MG CAPSULE

00740713	APO-DOXY	APX
00817120	DOXYCIN	RIV
02351234	DOXYCYCLINE	SAN
00725250	TEVA-DOXYCYCLINE	TEV

100MG TABLET

00874256	APO-DOXY	APX
00860751	DOXYCIN	RIV
02351242	DOXYCYCLINE	SAN
00887064	DOXYTAB	PDL
02158574	TEVA-DOXYCYCLINE	TEV

08:12.24 TETRACYCLINES

MINOCYCLINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For patients who cannot tolerate other tetracyclines or doxycycline.
For patients with severe widespread acne who have failed on tetracycline or doxycycline.

50MG CAPSULE

02084090	APO-MINOCYCLINE	APX
02239667	DOM-MINOCYCLINE	DPC
02153394	MINOCYCLINE	PDL
02287226	MINOCYCLINE	SAN
02230735	MYLAN-MINOCYCLINE	MYL
02294419	PMS-MINOCYCLINE	PMS
02237313	SANDOZ MINOCYCLINE	SDZ
02108143	TEVA-MINOCYCLINE	TEV

100MG CAPSULE

02084104	APO-MINOCYCLINE	APX
02239668	DOM-MINOCYCLINE	DPC
02154366	MINOCYCLINE	PDL
02239982	MINOCYCLINE	IVX
02287234	MINOCYCLINE	SAN
02230736	MYLAN-MINOCYCLINE	MYL
02294427	PMS-MINOCYCLINE	PMS
02237314	SANDOZ MINOCYCLINE	SDZ
02108151	TEVA-MINOCYCLINE	TEV

TETRACYCLINE HYDROCHLORIDE

250MG CAPSULE

00580929	TETRACYCLINE	AAP

08:12.28 MISCELLANEOUS ANTIBIOTICS

CLINDAMYCIN HYDROCHLORIDE

150MG CAPSULE

02245232	APO-CLINDAMYCIN	APX
02436906	AURO-CLINDAMYCIN	AUR
02400529	CLINDAMYCIN	SAN
02248525	CLINDAMYCINE	PDL
00030570	DALACIN C	PFI
02258331	MYLAN-CLINDAMYCIN	MYL
02241709	TEVA-CLINDAMYCIN	TEV

300MG CAPSULE

02245233	APO-CLINDAMYCIN	APX
02436914	AURO-CLINDAMYCIN	AUR
02400537	CLINDAMYCIN	SAN
02248526	CLINDAMYCINE	PDL
02182866	DALACIN C	PFI
02258358	MYLAN-CLINDAMYCIN	MYL
02241710	TEVA-CLINDAMYCIN	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99506008	CLINDAMYCIN STERILE INFUSION	UNK

CLINDAMYCIN PALMITATE HYDROCHLORIDE

15MG/ML POWDER FOR SOLUTION

00225851	DALACIN C	PFI

08:12.28 MISCELLANEOUS ANTIBIOTICS

CLINDAMYCIN PHOSPHATE

150MG/ML INJECTION

02139286	CLINDAMYCIN	FKD
02230535	CLINDAMYCIN	SDZ
02230540	CLINDAMYCIN	SDZ
02385716	CLINDAMYCIN	SDZ
00260436	DALACIN C PHOSPHATE	PFI
02215683	NOVO-CLINDAMYCIN	NOP

LINEZOLID

Limited use benefit (prior approval required).

Tablets:
For treatment of proven vancomycin-resistant enterococci (VRE) infections.
For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

I.V. Solution:
When linezolid cannot be administered orally in the above mentioned situations;

2MG/ML SOLUTION

02402637	LINEZOLID	TEV
02243685	ZYVOXAM	PFI

600MG TABLET

02426552	APO-LINEZOLID	APX
02422689	SANDOZ LINEZOLID	SDZ
02243684	ZYVOXAM	PFI

RIFAXIMIN

Limited use benefit (prior approval required).

For reducing the risk of overt hepatic encephalopathy (HE) recurrence in patients:
- Who are unable to achieve adequate control of HE recurrence with a maximal tolerated dose of lactulose alone; AND
- When used in combination with a maximal tolerated dose of lactulose.

550MG TABLET

02410702	ZAXINE	SLX

VANCOMYCIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients diagnosed with symptomatic Clostridium difficile infection who:
- are allergic, resistant or intolerant to metronidazole; OR
- have failed to respond to 4-6 days of oral metronidazole at doses of 500mg three times a day; OR
- have severe disease and initial doses are prescribed/recommended by an infectious disease or gastro-intestinal specialist.

125MG CAPSULE

02407744	JAMP-VANCOMYCIN	JMP
02430185	PMS-VANCOMYCIN	PMS
00800430	VANCOCIN	MRL
02377470	VANCOMYCIN	FKD
02380544	VANCOMYCIN	UNK

250MG CAPSULE

02407752	JAMP-VANCOMYCIN	JMP
00788716	VANCOCIN	MRL

08:12.28 MISCELLANEOUS ANTIBIOTICS

VANCOMYCIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients diagnosed with symptomatic Clostridium difficile infection who:
- are allergic, resistant or intolerant to metronidazole; OR
- have failed to respond to 4-6 days of oral metronidazole at doses of 500mg three times a day; OR
- have severe disease and initial doses are prescribed/recommended by an infectious disease or gastro-intestinal specialist.

250MG CAPSULE

02377489	VANCOMYCIN	FKD
02380552	VANCOMYCIN	UNK

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

02420295	JAMP-VANCOMYCIN	JMP
02406535	MYLAN-VANCOMYCIN	MYL
02342855	VAL-VANCOMYCIN	VAE
02139375	VANCOMYCIN	FKD
02230191	VANCOMYCIN	PFI
02394626	VANCOMYCIN	SDZ
02407914	VANCOMYCIN	MYL
02411032	VANCOMYCIN	RAX
02435713	VANCOMYCIN	GMP

1,000MG POWDER FOR SOLUTION

02230192	VANCOMYCIN	PFI
02396386	VANCOMYCIN	RAX
02435721	VANCOMYCIN	GMP

1G POWDER FOR SOLUTION

02420309	JAMP-VANCOMYCIN	JMP
02406543	MYLAN-VANCOMYCIN	MYL
02241821	PMS-VANCOMYCIN 1 G	PMS
02342863	VAL-VANCOMYCIN	VAE
02139383	VANCOMYCIN	FKD
02394634	VANCOMYCIN	SDZ
02407922	VANCOMYCIN	MYL

5G POWDER FOR SOLUTION

02420317	JAMP-VANCOMYCIN	JMP
02406551	MYLAN-VANCOMYCIN	MYL
02139243	VANCOMYCIN	FKD
02378337	VANCOMYCIN	PFI
02394642	VANCOMYCIN	SDZ
02407930	VANCOMYCIN	MYL

10G POWDER FOR SOLUTION

02420325	JAMP-VANCOMYCIN	JMP
02406578	MYLAN-VANCOMYCIN	MYL
02405830	VAL-VANCOMYCIN	VAE
02241807	VANCOMYCIN	FKD
02378345	VANCOMYCIN	PFI
02394650	VANCOMYCIN	SDZ
02407949	VANCOMYCIN	MYL
02411040	VANCOMYCIN	RAX

08:14.04 ALLYLAMINES

TERBINAFINE HYDROCHLORIDE

250MG TABLET

02254727	ACT TERBINAFINE	ACG
02239893	APO-TERBINAFINE	APX
02320134	AURO-TERBINAFINE	AUR
02299275	DOM-TERBINAFINE	DPC
02357070	JAMP-TERBINAFINE	JMP
02031116	LAMISIL	NVR
02240807	PMS-TERBINAFINE	PMS
02294273	PMS-TERBINAFINE	PMS
02262924	RIVA-TERBINAFINE	RIV
02242735	TERBINAFINE	PDL
02353121	TERBINAFINE	SAN
02385279	TERBINAFINE	SIV
02240346	TEVA-TERBINAFINE	TEV

08:14.08 AZOLES

FLUCONAZOLE

150MG CAPSULE

02241895	APO-FLUCONAZOLE	APX
02311690	CANESORAL	BAY
02323419	CO FLUCONAZOLE	OBT
02141442	DIFLUCAN	PFI
02432471	JAMP-FLUCONAZOLE	JMP
02428792	MAR-FLUCONAZOLE	MAR
02243645	NOVO-FLUCONAZOLE	NOP
02246620	PMS-FLUCONAZOLE	PMS
02282348	PMS-FLUCONAZOLE	PMS
02433702	PRIVA-FLUCONAZOLE	PHA
02255510	RIVA-FLUCONAZOLE	RIV

10MG/ML POWDER FOR SOLUTION

02024152	DIFLUCAN	PFI

50MG TABLET

02281260	ACT FLUCONAZOLE	ACG
02237370	APO-FLUCONAZOLE	APX
00891800	DIFLUCAN	PFI
02245292	MYLAN-FLUCONAZOLE	MYL
02245643	PMS-FLUCONAZOLE	PMS
02249294	TARO-FLUCONAZOLE	TAR
02236978	TEVA-FLUCONAZOLE	TEV

100MG TABLET

02281279	ACT FLUCONAZOLE	ACG
02237371	APO-FLUCONAZOLE	APX
02246109	DOM-FLUCONAZOLE	DPC
02245293	MYLAN-FLUCONAZOLE	MYL
02245644	PMS-FLUCONAZOLE	PMS
02310686	PRO-FLUCONAZOLE	PDL
02249308	TARO-FLUCONAZOLE	TAR
02236979	TEVA-FLUCONAZOLE	TEV

ITRACONAZOLE

100MG CAPSULE

02462559	MINT-ITRACONAZOLE	MIN
02047454	SPORANOX	JSO

10MG/ML SOLUTION

02231347	SPORANOX	JSO

08:14.08 AZOLES

KETOCONAZOLE

200MG TABLET

02237235	APO-KETOCONAZOLE	APX
02231061	TEVA-KETOCONAZOLE	TEV

VORICONAZOLE

Limited use benefit (prior approval required).

For the treatment of patients with invasive aspergillosis; OR
For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

50MG TABLET

02409674	APO-VORICONAZOLE	APX
02399245	SANDOZ VORICONAZOLE	SDZ
02396866	TEVA-VORICONAZOLE	TEV
02256460	VFEND	PFI

200MG TABLET

02409682	APO-VORICONAZOLE	APX
02399253	SANDOZ VORICONAZOLE	SDZ
02396874	TEVA-VORICONAZOLE	TEV
02256479	VFEND	PFI

08:14.28 POLYENES

NYSTATIN

100,000U/ML SUSPENSION

02125145	DOM-NYSTATIN	DPC
02433443	JAMP-NYSTATIN	JMP
00792667	PMS-NYSTATIN	PMS
02194201	RATIO-NYSTATIN	TEV

08:16.04 ANTITUBERCULOSIS AGENTS

ETHAMBUTOL HYDROCHLORIDE

100MG TABLET

00247960	ETIBI	VAE

400MG TABLET

00247979	ETIBI	VAE

ISONIAZID

10MG/ML SOLUTION

00265500	ISOTAMINE	VAE
00577812	PDP-ISONIAZID	PED

100MG TABLET

00261270	ISOTAMINE	VAE
00577790	PDP-ISONIAZID	PED

300MG TABLET

00272655	ISOTAMINE	VAE
00577804	PDP-ISONIAZID	PED

PDIN FOR EXTEMPORANEOUS MIXTURE

99503031	ISONIAZID ORAL LIQUID	UNK

PYRAZINAMIDE

500MG TABLET

00618810	PDP-PYRAZINAMIDE	PED
00283991	TEBRAZID	VAE

RIFABUTIN

150MG CAPSULE

02063786	MYCOBUTIN	PFI

08:16.04 ANTITUBERCULOSIS AGENTS

RIFAMPIN

150MG CAPSULE

02091887	RIFADIN	SAC
00393444	ROFACT	VAE

300MG CAPSULE

02092808	RIFADIN	SAC
00343617	ROFACT	VAE

PDIN FOR EXTEMPORANEOUS MIXTURE

99503022	RIFAMPIN ORAL LIQUID	UNK

08:16.92 MISCELLANEOUS ANTIMYCOBACTERIALS

DAPSONE

100MG TABLET

02041510	DAPSONE	JAC

08:18.04 ADAMANTANES

AMANTADINE HYDROCHLORIDE

100MG CAPSULE

02130963	DOM-AMANTADINE	DPC
01990403	PMS-AMANTADINE	PED

10MG/ML SYRUP

02022826	PMS-AMANTADINE	PED

08:18.08 ANTIRETROVIRALS

ABACAVIR SUFLATE, LAMIVUDINE

600MG & 300MG TABLET

02458381	PMS-ABACAVIR/LAMIVUDINE	PMS

ABACAVIR SULFATE

20MG/ML SOLUTION

02240358	ZIAGEN	VII

300MG TABLET

02396769	APO-ABACAVIR	APX
02240357	ZIAGEN	VII

ABACAVIR SULFATE, LAMIVUDINE

600MG & 300MG TABLET

02399539	APO-ABACAVIR-LAMIVUDINE	APX
02454513	AURO-ABACAVIR/LAMIVUDINE	AUR
02269341	KIVEXA	VII
02450682	MYLAN-ABACAVIR/LAMIVUDINE	MYL
02416662	TEVA-ABACAVIR/LAMIVUDINE	TEV

ABACAVIR SULFATE, LAMIVUDINE, DOLUTEGRAVIR SODIUM

600MG & 300MG & 50MG TABLET

02430932	TRIUMEQ	VII

ABACAVIR SULFATE, LAMIVUDINE, ZIDOVUDINE

300MG & 150MG & 300MG TABLET

02416255	APO-ABACAVIR-LAMIVUDINE-ZIDOVUDINE	APX
02244757	TRIZIVIR	VII

ATAZANAVIR SULFATE

150MG CAPSULE

02456877	MYLAN-ATAZANAVIR	MYL
02248610	REYATAZ	BMS

08:18.08 ANTIRETROVIRALS

ATAZANAVIR SULFATE

150MG CAPSULE

02443791	TEVA-ATAZANAVIR	TEV

200MG CAPSULE

02456885	MYLAN-ATAZANAVIR	MYL
02248611	REYATAZ	BMS
02443813	TEVA-ATAZANAVIR	TEV

300MG CAPSULE

02456893	MYLAN-ATAZANAVIR	MYL
02294176	REYATAZ	BMS
02443821	TEVA-ATAZANAVIR	TEV

DARUNAVIR ETHANOLATE

75MG TABLET

02338432	PREZISTA	JSO

150MG TABLET

02369753	PREZISTA	JSO

400MG TABLET

02324016	PREZISTA	JSO

600MG TABLET

02324024	PREZISTA	JSO

800MG TABLET

02393050	PREZISTA	JSO

DARUNAVIR ETHANOLATE, COBICISTAT

150MG & 800MG TABLET

02426501	PREZCOBIX	JSO

DIDANOSINE

125MG CAPSULE (ENTERIC COATED)

02244596	VIDEX EC	BMS

200MG CAPSULE (ENTERIC COATED)

02244597	VIDEX EC	BMS

250MG CAPSULE (ENTERIC COATED)

02244598	VIDEX EC	BMS

400MG CAPSULE (ENTERIC COATED)

02244599	VIDEX EC	BMS

DOLUTEGRAVIR SODIUM

50MG TABLET

02414945	TIVICAY	VII

EFAVIRENZ

50MG CAPSULE

02239886	SUSTIVA	BMS

200MG CAPSULE

02239888	SUSTIVA	BMS

600MG TABLET

02418428	AURO-EFAVIRENZ	AUR
02381524	MYLAN-EFAVIRENZ	MYL
02246045	SUSTIVA	BMS
02389762	TEVA-EFAVIRENZ	TEV

EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL FUMARATE

600MG & 200MG & 300MG TABLET

02300699	ATRIPLA	BMS

08:18.08 ANTIRETROVIRALS

EFAVIRENZ, EMTRICITABINE, TENOFOVIR DISOPROXIL FUMARATE

600MG & 200MG & 300MG TABLET

02461412	MYLAN-EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	MYL
02393549	TEVA-EFAVIRENZ/EMTRICITABINE/TENOFOVIR	TEV

EMTRICITABINE, COBICISTAT, ELVITEGRAVIR, TENOFOVIR ALAFENAMIDE

200MG & 150MG & 150MG & 10MG TABLET

02449498	GENVOYA	GIL

ETRAVIRINE

100MG TABLET

02306778	INTELENCE	JSO

200MG TABLET

02375931	INTELENCE	JSO

FOSAMPRENAVIR CALCIUM

50MG/ML SUSPENSION

02261553	TELZIR	VII

700MG TABLET

02261545	TELZIR	VII

LAMIVUDINE

5MG SOLUTION

02239194	HEPTOVIR	GSK

10MG/ML SOLUTION

02192691	3TC	VII

100MG TABLET

02393239	APO-LAMIVUDINE HBV	APX
02239193	HEPTOVIR	GSK

150MG TABLET

02192683	3TC	VII
02369052	APO-LAMIVUDINE	APX

300MG TABLET

02247825	3TC	VII
02369060	APO-LAMIVUDINE	APX

LAMIVUDINE, ZIDOVUDINE

150MG & 300MG TABLET

02375540	APO-LAMIVUDINE-ZIDOVUDINE	APX
02414414	AURO-LAMIVUDINE/ZIDOVUDINE	AUR
02239213	COMBIVIR	VII
02387247	TEVA-LAMIVUDINE/ZIDOVUDINE	TEV

LOPINAVIR, RITONAVIR

80MG & 20MG/ML SOLUTION

02243644	KALETRA	ABV

100MG & 25MG TABLET

02312301	KALETRA	ABV

200MG & 50MG TABLET

02285533	KALETRA	ABV

MARAVIROC

150MG TABLET

02299844	CELSENTRI	VII

08:18.08 ANTIRETROVIRALS

MARAVIROC

300MG TABLET

02299852	CELSENTRI	VII

NELFINAVIR MESYLATE

50MG/G POWDER

02238618	VIRACEPT	PFI

250MG TABLET

02238617	VIRACEPT	PFI

625MG TABLET

02248761	VIRACEPT	PFI

NEVIRAPINE

200MG TABLET

02318601	AURO-NEVIRAPINE	APL
02387727	MYLAN-NEVIRAPINE	MYL
02405776	PMS-NEVIRAPINE	PMS
02352893	TEVA-NEVIRAPINE	TEV
02238748	VIRAMUNE	BOE

400MG TABLET (EXTENDED RELEASE)

02427931	APO-NEVIRAPINE XR	APX
02367289	VIRAMUNE XR	BOE

RALTEGRAVIR POTASSIUM

400MG TABLET

02301881	ISENTRESS	FRS

RILPIVIRINE HYDROCHLORIDE

25MG TABLET

02370603	EDURANT	JSO

RITONAVIR

80MG/ML SOLUTION

02229145	NORVIR	ABV

100MG TABLET

02357593	NORVIR	ABV

SAQUINAVIR MESYLATE

200MG CAPSULE

02216965	INVIRASE	HLR

500MG TABLET

02279320	INVIRASE	HLR

STAVUDINE

15MG CAPSULE

02216086	ZERIT	BMS

20MG CAPSULE

02216094	ZERIT	BMS

30MG CAPSULE

02216108	ZERIT	BMS

40MG CAPSULE

02216116	ZERIT	BMS

08:18.08 ANTIRETROVIRALS

TENOFOVIR DISOPROXIL FUMARATE

Limited use benefit (prior approval required).

For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative agent.
For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2,000 IU/mL.

245MG TABLET

02247128	VIREAD	GIL

300MG TABLET

02451980	APO-TENOFOVIR	APX
02460173	AURO-TENOFOVIR	AUR
02452634	MYLAN-TENOFOVIR DISOPROXIL	MYL
02403889	TEVA-TENOFOVIR	TEV

TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE

200MG & 300MG TABLET

02274906	TRUVADA	GIL

300MG & 200MG TABLET

02452006	APO-EMTRICITABINE-TENOFOVIR	APX
02443902	MYLAN-EMTRICITABINE/TENOFOVIR DISOPROXIL	MYL
02461110	PMS-EMTRICITABINE-TENOFOVIR	PMS
02399059	TEVA-EMTRICITABINE/TENOFOVIR	TEV

TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, COBICISTAT, ELVITEGRAVIR

150MG & 200MG & 150MG & 300MG TABLET

02397137	STRIBILD	GIL

TENOFOVIR DISOPROXIL FUMARATE, EMTRICITABINE, RILPIVIRINE HYDROCHLORIDE

200MG & 25MG & 300MG TABLET

02374129	COMPLERA	GIL

TIPRANAVIR

250MG CAPSULE

02273322	APTIVUS	BOE

ZIDOVUDINE

100MG CAPSULE

01946323	APO-ZIDOVUDINE	APX
01902660	RETROVIR	VII

10MG/ML SYRUP

01902652	RETROVIR	VII

08:18.20 INTERFERONS

INTERFERON ALFA-2B

6,000,000IU/ML SOLUTION

02238674	INTRON A	FRS

10,000,000IU/ML SOLUTION

02238675	INTRON A	FRS

10,000,000IU/VIAL SOLUTION

02223406	INTRON A	FRS

15,000,000IU/ML SOLUTION

02240693	INTRON A	FRS

08:18.20 INTERFERONS

INTERFERON ALFA-2B

25,000,000IU/ML SOLUTION

02240694	INTRON A	FRS

50,000,000IU/ML SOLUTION

02240695	INTRON A	FRS

PEGINTERFERON ALFA-2A

Limited use benefit (prior approval required).

For the treatment of patients with chronic hepatitis B infection who have a HBV DNA concentration above 2,000 IU/mL without decompensated cirrhosis, upon the written request of a hepatologist or other specialist in this area.

180MCG/0.5ML SOLUTION

02248077	PEGASYS	HLR

PEGINTERFERON ALFA-2A, RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.
- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

180MCG/0.5ML & 200MG KIT

02253429	PEGASYS RBV	HLR

180MCG/1ML & 200MG KIT

02253410	PEGASYS RBV	HLR

PEGINTERFERON ALFA-2B, RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.
- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

50MCG/0.5ML & 200MG KIT

02254573	PEGETRON KIT	FRS

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ACYCLOVIR

40MG/ML SUSPENSION

00886157	ZOVIRAX	GSK

200MG TABLET

02207621	APO-ACYCLOVIR	APX
02242784	MYLAN-ACYCLOVIR	MYL
02078627	RATIO-ACYCLOVIR	TEV
02285959	TEVA-ACYCLOVIR	TEV

400MG TABLET

02207648	APO-ACYCLOVIR	APX
02242463	MYLAN-ACYCLOVIR	MYL
02078635	RATIO-ACYCLOVIR	TEV

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ACYCLOVIR

400MG TABLET

02285967	TEVA-ACYCLOVIR	TEV

800MG TABLET

02207656	APO-ACYCLOVIR	APX
02242464	MYLAN-ACYCLOVIR	MYL
02078651	RATIO-ACYCLOVIR	TEV
02285975	TEVA-ACYCLOVIR	TEV

ADEFOVIR DIPIVOXIL

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection when used in combination with lamivudine in patients who have developed failure to lamivudine, as defined by an increase in HBV DNA of ≥ 1 log10 IU/mL above the nadir, measured on two separate occasions within an interval of at least one month, after the first three months of lamivudine therapy, and when failure to lamivudine is not due to poor adherence to therapy.

10MG TABLET

02420333	APO-ADEFOVIR	APX
02247823	HEPSERA	GIL

ENTECAVIR MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection in patients with cirrhosis documented on radiologic or histologic grounds and a HBV DNA concentration above 2000IU/mL.

0.5MG TABLET

02396955	APO-ENTECAVIR	APX
02448777	AURO-ENTECAVIR	AUR
02282224	BARACLUDE	BMS
02430576	PMS-ENTECAVIR	PMS

FAMCICLOVIR

125MG TABLET

02305682	ACT FAMCICLOVIR	ACG
02292025	APO-FAMCICLOVIR	APX
02324865	FAMCICLOVIR	PDL
02229110	FAMVIR	NVR
02278081	PMS-FAMCICLOVIR	PMS
02278634	SANDOZ FAMCICLOVIR	SDZ

250MG TABLET

02305690	ACT FAMCICLOVIR	ACG
02292041	APO-FAMCICLOVIR	APX
02324873	FAMCICLOVIR	PDL
02229129	FAMVIR	NVR
02278103	PMS-FAMCICLOVIR	PMS
02278642	SANDOZ FAMCICLOVIR	SDZ

500MG TABLET

02305704	ACT FAMCICLOVIR	ACG
02292068	APO-FAMCICLOVIR	APX
02177102	FAMVIR	NVR
02278111	PMS-FAMCICLOVIR	PMS
02278650	SANDOZ FAMCICLOVIR	SDZ

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

GANCICLOVIR SODIUM

500MG POWDER FOR SOLUTION

02162695	CYTOVENE	HLR

VALACYCLOVIR HYDROCHLORIDE

500MG TABLET

02295822	APO-VALACYCLOVIR	APX
02405040	AURO-VALACYCLOVIR	AUR
02331748	CO VALACYCLOVIR	OBT
02307936	DOM-VALACYCLOVIR	DPC
02441454	JAMP-VALACYCLOVIR	JMP
02441586	MAR-VALACYCLOVIR	MAR
02351579	MYLAN-VALACYCLOVIR	MYL
02298457	PMS-VALACYCLOVIR	PMS
02441861	PRIVA-VALACYCLOVIR	PHA
02315173	PRO-VALACYCLOVIR	PDL
02316447	RIVA-VALACYCLOVIR	RIV
02347091	SANDOZ VALACYCLOVIR	SDZ
02357534	TEVA-VALACYCLOVIR	TEV
02442000	VALACYCLOVIR	SIV
02454645	VALACYCLOVIR	SAN
02219492	VALTREX	GSK

VALGANCICLOVIR HYDROCHLORIDE

50MG POWDER FOR SOLUTION

02306085	VALCYTE	HLR

450MG TABLET

02393824	APO-VALGANCICLOVIR	APX
02435179	AURO-VALGANCICLOVIR	AUR
02413825	TEVA-VALGANCICLOVIR	TEV
02245777	VALCYTE	HLR

08:18.40 HCV ANTIVIRALS

DACLATASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

30MG TABLET

02444747	DAKLINZA	BMS

60MG TABLET

02444755	DAKLINZA	BMS

08:18.40 HCV ANTIVIRALS

ELBASVIR, GRAZOPREVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

50MG & 100MG TABLET

02451131	ZEPATIER	FRS

OMBITASVIR, PARITAPREVIR, RITONAVIR, DASABUVIR

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C virus (HCV) Genotype 1 infection in adults with a liver fibrosis stage ≥ F2 (Metavir score or equivalent);
AND
Patient is unable to take the following chronic hepatitis C medications based on intolerance/contraindication:

- Epclusa (sofosbuvir-velpatasvir)
- Harvoni (ledipasvir-sofosbuvir)
- Zepatier (elbasvir-grazoprevir)
- Daklinza (daclatasvir) + Sunvepra (asunaprevir)

Criteria & Duration
Treatment naïve and experienced Genotype 1b, non-cirrhotic* - 12 weeks.
Treatment naïve and experienced Genotype 1a, non-cirrhotic - 12 weeks in combination with RBV.
Treatment naïve and experienced Genotype1b, cirrhotic - 12 weeks in combination with RBV.
Treatment naïve and experienced (prior relapses and prior partial responders) Genotype 1a, cirrhotic - 12 weeks in combination with RBV.
Treatment experienced Genotype 1a, with cirrhosis, and who have had a previous null response to pegIFN and RBV - 24 weeks in combination with RBV.

*Holkira Pak with ribavirin is recommended in patients with an unknown Genotype 1 subtype or with mixed Genotype 1 infection.

250MG & 12.5MG & 75MG & 50MG TABLET

02436027	HOLKIRA PAK	ABV

RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C.

200MG TABLET

02439212	IBAVYR	PED

400MG TABLET

02425890	IBAVYR	PED

600MG TABLET

02425904	IBAVYR	PED

08:18.40 HCV ANTIVIRALS

SIMEPREVIR SODIUM

Limited use benefit (prior approval required).

For the treatment of chronic Hepatitis C in treatment-naïve and treatment-experienced patients who meet all of the following criteria:

- Chronic hepatitis C virus (HCV) genotype 1 infection; AND
- Detectable levels of HCV RNA in the last six months; AND
- Fibrosis stage F2 or greater (Metavir scale or equivalent); AND
- Patient has not received a prior full therapeutic course of boceprevir or telaprevir.

Not eligible for coverage:

- Patients currently being treated with another HCV antiviral agent.
- Patients who have previously received a treatment course of Galexos (Re-treatment requests will not be considered).

150MG CAPSULE

02416441	GALEXOS	JSO

SOFOSBUVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND

Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG TABLET

02418355	SOVALDI	GIL

SOFOSBUVIR, LEDIPASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG & 90MG TABLET

02432226	HARVONI	GIL

08:18.40 HCV ANTIVIRALS

SOFOSBUVIR, VELPATASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG & 100MG TABLET

02456370	EPCLUSA	GIL

08:30.04 AMEBICIDES

PAROMOMYCIN SULFATE

250MG CAPSULE

02078759	HUMATIN	ERF

08:30.08 ANTIMALARIALS

CHLOROQUINE PHOSPHATE

250MG TABLET

00021261	TEVA-CHLOROQUINE	TEV

HYDROXYCHLOROQUINE SULFATE

200MG TABLET

02246691	APO-HYDROXYQUINE	APX
02424991	MINT-HYDROXYCHLOROQUINE	MIN
02252600	MYLAN-HYDROXYCHLOROQUINE	MYL
02017709	PLAQUENIL	SAC
02311011	PRO-HYDROXYQUINE	PDL

PRIMAQUINE PHOSPHATE

26.3MG TABLET

02017776	PRIMAQUINE	SAC

08:30.92 MISCELLANEOUS ANTIPROTOZOALS

ATOVAQUONE

150MG/ML SUSPENSION

02217422	MEPRON	GSK

METRONIDAZOLE

500MG CAPSULE

01926853	FLAGYL	ODN
02248562	METRONIDAZOLE	AAP
00783137	PMS-METRONIDAZOLE	PMS

250MG TABLET

00545066	METRONIDAZOLE	AAP

PDIN FOR EXTEMPORANEOUS MIXTURE

99503012	METRONIDAZOLE ORAL LIQUID	UNK

08:36.00 URINARY ANTI-INFECTIVES

FOSFOMYCIN TROMETHAMINE

Limited use benefit (prior approval required).

For the treatment of women (>12 years old) with:
- Urinary tract infections with organisms resistant to first line therapy; OR
- Urinary tract infections in pregnancy when first-line agents are contraindicated.

3G/PK POWDER

02240335	MONUROL	PAL

NITROFURANTOIN

50MG CAPSULE

02231015	TEVA-NITROFURANTOIN	TEV

100MG CAPSULE

02063662	MACROBID	ALL
02231016	TEVA-NITROFURANTOIN	TEV

50MG TABLET

00319511	NITROFURANTOIN	AAP

100MG TABLET

00312738	NITROFURANTOIN	AAP

PDIN FOR EXTEMPORANEOUS MIXTURE

99503004	NITRO-FURANTOIN ORAL LIQUID	UNK

TRIMETHOPRIM

100MG TABLET

02243116	TRIMETHOPRIM	AAP

200MG TABLET

02243117	TRIMETHOPRIM	AAP

PDIN FOR EXTEMPORANEOUS MIXTURE

99503017	TRIMETHOPRIM ORAL LIQUID	UNK

10:00 ANTINEOPLASTIC AGENTS

10:00.00 ANTINEOPLASTIC AGENTS

ABIRATERONE ACETATE

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 months)
For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) and who have not received prior chemotherapy if they meet the following criteria:
- Used in combination with prednisone; AND
- Patient has an ECOG performance status of 0 or 1.

For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who progressed on docetaxel-based chemotherapy if they meet the following criteria:
- Used in combination with prednisone; AND
- Patient has an ECOG performance status ≤ 2; AND
- Abiraterone is not used as an add-on therapy to enzalutamide (Xtandi); AND
- Abiraterone has not been used in the pre-docetaxel setting.

Renewal coverage criteria (Renewal for 12 months)
There is no objective evidence of disease progression

250MG TABLET

02371065	ZYTIGA	JSO

500MG TABLET

02457113	ZYTIGA	JSO

AFATINIB DIMALEATE

Limited use benefit (prior approval required).

For the treatment of patients with advanced Non-Small Cell Lung Cancer (NSCLC) who meet ALL of the following criteria:
- First line treatment of patients; AND
- EGFR mutation positive; AND
- Advanced or metastatic adenocarcinoma of the lung; AND
- An ECOG performance status of 0 or 1.

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

Use of afatinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy.

20MG TABLET

02415666	GIOTRIF	BOE

30MG TABLET

02415674	GIOTRIF	BOE

40MG TABLET

02415682	GIOTRIF	BOE

ANASTROZOLE

1MG TABLET

02351218	ACH-ANASTROZOLE	ACC
02394898	ACT ANASTROZOLE	ACG
02395649	ANASTROZOLE	PDL
02442736	ANASTROZOLE	SAN
02374420	APO-ANASTROZOLE	APX
02224135	ARIMIDEX	AZC
02392488	BIO-ANASTROZOLE	BMI
02339080	JAMP-ANASTROZOLE	JMP
02379562	MAR-ANASTROZOLE	MAR
02379104	MED-ANASTROZOLE	GMP

10:00.00 ANTINEOPLASTIC AGENTS

ANASTROZOLE

1MG TABLET

02393573	MINT-ANASTROZOLE	MIN
02417855	NAT-ANASTROZOLE	NPH
02320738	PMS-ANASTROZOLE	PMS
02328690	RAN-ANASTROZOLE	RBY
02392259	RIVA-ANASTROZOLE	RIV
02338467	SANDOZ ANASTROZOLE	SDZ
02365650	TARO-ANASTROZOLE	TAR
02313049	TEVA-ANASTROZOLE	TEV
02427818	VAN-ANASTROZOLE	VAN

BICALUTAMIDE

50MG TABLET

02325985	ACH-BICALUTAMIDE	ACC
02274337	ACT BICALUTAMIDE	ACG
02296063	APO-BICALUTAMIDE	APX
02382423	BICALUTAMIDE	SIV
02184478	CASODEX	AZC
02357216	JAMP-BICALUTAMIDE	JMP
02275589	PMS-BICALUTAMIDE	PMS
02311038	PRO-BICALUTAMIDE	PDL
02371324	RAN-BICALUTAMIDE	RBY
02276089	SANDOZ BICALUTAMIDE	SDZ
02270226	TEVA-BICALUTAMIDE	TEV
02428709	VAN-BICALUTAMIDE	VAN

BUSERELIN ACETATE

6.3MG/IMPLANT IMPLANT

02228955	SUPREFACT DEPOT 2 MONTHS	SAC

9.45MG/IMPLANT IMPLANT

02240749	SUPREFACT DEPOT 3 MONTHS	SAC

1MG/ML SOLUTION

02225166	SUPREFACT	SAC
02225158	SUPREFACT (NASAL)	SAC

BUSULFAN

2MG TABLET

00004618	MYLERAN	ASP

CAPECITABINE

150MG TABLET

02426757	ACH-CAPECITABINE	ACC
02421917	SANDOZ CAPECITABINE	SDZ
02457490	TARO-CAPECITABINE	TAR
02400022	TEVA-CAPECITABINE	TEV
02238453	XELODA	HLR

500MG TABLET

02426765	ACH-CAPECITABINE	ACC
02421925	SANDOZ CAPECITABINE	SDZ
02457504	TARO-CAPECITABINE	TAR
02400030	TEVA-CAPECITABINE	TEV
02238454	XELODA	HLR

CHLORAMBUCIL

2MG TABLET

00004626	LEUKERAN	ASP

COBIMETINIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for cobimetinib (Cotellic):
For the first-line treatment of patients with metastatic or unresectable melanoma in combination with vemurafenib (Zelboraf).

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

20MG TABLET

02452340	COTELLIC	HLR

CYCLOPHOSPHAMIDE

25MG TABLET

02241795	PROCYTOX	BAX

50MG TABLET

02241796	PROCYTOX	BAX

DABRAFENIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for dabrafenib (Tafinlar):
- For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
- For the first-line treatment of patients with metastatic or unresectable melanoma in combination with trametinib (Mekinist)

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG* performance status of 0 to 1;

*ECOG = European Cooperative Oncology Group Status

AND
- Patient is previously untreated.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

50MG CAPSULE

02409607	TAFINLAR	NVR

75MG CAPSULE

02409615	TAFINLAR	NVR

DEGARELIX ACETATE

80MG POWDER FOR SOLUTION

02337029	FIRMAGON	FEI

120MG POWDER FOR SOLUTION

02337037	FIRMAGON	FEI

ENZALUTAMIDE

Limited use benefit (prior approval required).

For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are/have:
- Asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) who have not received prior chemotherapy; AND
- Have an ECOG performance status of 0 or 1 with no risk factors for seizures; OR
- Progressed on docetaxel-based chemotherapy with an ECOG performance status ≤2 and no risk factors for seizures; AND
- Would be an alternative to abiraterone for patients in the post-docetaxel setting but would not be an add-on therapy to abiraterone treatment.

Patients previously treated with abiraterone would not be eligible for enzalutamide unless unable to tolerate abiraterone.

Use of enzalutamide in the post-docetaxel setting is not permitted if previously used in the pre-chemotherapy setting.

40MG CAPSULE

02407329	XTANDI	AST

ERLOTINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Treatment of non-small cell lung cancer (NSCLC) after failure of at least one prior chemotherapy regimen, and whose EGFR expression status is positive or unknown.

25MG TABLET

02461862	APO-ERLOTINIB	APX
02269007	TARCEVA	HLR
02377691	TEVA-ERLOTINIB	TEV

100MG TABLET

02461870	APO-ERLOTINIB	APX
02454386	PMS-ERLOTINIB	PMS
02269015	TARCEVA	HLR
02377705	TEVA-ERLOTINIB	TEV

150MG TABLET

02461889	APO-ERLOTINIB	APX
02454394	PMS-ERLOTINIB	PMS
02269023	TARCEVA	HLR
02377713	TEVA-ERLOTINIB	TEV

ETOPOSIDE

50MG CAPSULE

00616192	VEPESID	BMS

EXEMESTANE

25MG TABLET

02390183	ACT EXEMESTANE	ACG
02419726	APO-EXEMESTANE	APX
02242705	AROMASIN	PFI
02407841	MED-EXEMESTANE	GMP
02408473	TEVA-EXEMESTANE	TEV

FLUDARABINE PHOSPHATE

10MG TABLET

02246226	FLUDARA	SAC

FLUTAMIDE

250MG TABLET

02238560	APO-FLUTAMIDE	APX
02230104	PMS-FLUTAMIDE	PMS
02230089	TEVA-FLUTAMIDE	TEV

HYDROXYUREA

500MG CAPSULE

02247937	APO-HYDROXYUREA	APX
00465283	HYDREA	BMS
02242920	MYLAN-HYDROXYUREA	MYL

IDELALISIB

Limited use benefit (prior approval required).

Criteria for initial six month coverage:
- For the treatment of patients with relapsed chronic lymphocytic leukemia (CLL) in combination with rituximab. Treatment should continue until unacceptable toxicity or disease progression.

Criteria for assessment every six months:
- There is no objective evidence of disease progression.

100MG TABLET

02438798	ZYDELIG	GIL

150MG TABLET

02438801	ZYDELIG	GIL

IMATINIB MESYLATE

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

100MG TABLET

02355337	APO-IMATINIB	APX
02253275	GLEEVEC	NVR
02397285	NAT-IMATINIB	NPH
02431114	PMS-IMATINIB	PMS
02399806	TEVA-IMATINIB	TEV

400MG TABLET

02355345	APO-IMATINIB	APX
02253283	GLEEVEC	NVR
02397293	NAT-IMATINIB	NPH
02431122	PMS-IMATINIB	PMS
02399814	TEVA-IMATINIB	TEV

LENALIDOMIDE

Limited use benefit (prior approval not required).

For the treatment of:
- Myelodysplastic syndrome (MDS)
- Refractory/relapsed Multiple Myeloma after one prior therapy (MM-AOPT)
- Newly diagnosed Multiple Myeloma for patients who are not eligible for autologous stem cell transplant - (MM-TNE)
- Maintenance treatment for newly diagnosed Multiple Myeloma post-autologous stem cell transplant – (NDMM post-ASCT)

(Please refer to Appendix A).

5MG CAPSULE

02304899	REVLIMID	UNK

10MG CAPSULE

02304902	REVLIMID	UNK

15MG CAPSULE

02317699	REVLIMID	UNK

20MG CAPSULE

02440601	REVLIMID	UNK

25MG CAPSULE

02317710	REVLIMID	UNK

LENVATINIB

Limited use benefit (prior approval required).

Initial coverage criteria (initial approval for 4 months):
- Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC); AND
- DTC is refractory to radioactive iodine treatment; AND
- Have an ECOG* performance status of ≤ 2;

AND

Patient meets the eligibility criteria of the SELECT trial as follows:
- Pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not eligible)
- Evidence of iodine-131 refractory disease according to at least one of the following criteria:
  - At least one measurable lesion without iodine uptake on any iodine-131 scan
  - At least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment
  - Total lifetime radioactive iodine dose greater than 600 mCi (millicurie)
- Radiologic evidence of progression within the previous 13 months
- No prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase inhibitor

Renewal coverage criteria (4 months):
There is no objective evidence of disease progression.

10MG CAPSULE

02450321	LENVIMA	EIS

14MG CAPSULE

02450313	LENVIMA	EIS

20MG CAPSULE

02450305	LENVIMA	EIS

10:00.00 ANTINEOPLASTIC AGENTS

LENVATINIB

Limited use benefit (prior approval required).

Initial coverage criteria (initial approval for 4 months):
- Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC); AND
- DTC is refractory to radioactive iodine treatment; AND
- Have an ECOG* performance status of ≤ 2;

AND

Patient meets the eligibility criteria of the SELECT trial as follows:
- Pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not eligible)
- Evidence of iodine-131 refractory disease according to at least one of the following criteria:

- At least one measurable lesion without iodine uptake on any iodine-131 scan
- At least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment
- Total lifetime radioactive iodine dose greater than 600 mCi (millicurie)

- Radiologic evidence of progression within the previous 13 months
- No prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase inhibitor

Renewal coverage criteria (4 months):
There is no objective evidence of disease progression.

24MG CAPSULE

02450291	LENVIMA	EIS

LETROZOLE

2.5MG TABLET

02338459	ACH-LETROZOLE	ACC
02358514	APO-LETROZOLE	APX
02392496	BIO-LETROZOLE	BMI
02231384	FEMARA	NVR
02373009	JAMP-LETROZOLE	JMP
02348969	LETROZOLE	ACG
02402025	LETROZOLE	PDL
02373424	MAR-LETROZOLE	MAR
02322315	MED-LETROZOLE	GMP
02421585	NAT-LETROZOLE	NPH
02309114	PMS-LETROZOLE	PMS
02372282	RAN-LETROZOLE	RBY
02398656	RIVA-LETROZOLE	RIV
02344815	SANDOZ LETROZOLE	SDZ
02343657	TEVA-LETROZOLE	TEV
02378213	ZINDA-LETROZOLE	UNK

LEUPROLIDE ACETATE

3.75MG/VIAL POWDER FOR SUSPENSION

00884502	LUPRON DEPOT	ABV

7.5MG/VIAL POWDER FOR SUSPENSION

00836273	LUPRON DEPOT	ABV

10.5MG/VIAL POWDER FOR SUSPENSION

02248239	ELIGARD	SAC

10:00.00 ANTINEOPLASTIC AGENTS

LEUPROLIDE ACETATE

11.25MG/VIAL POWDER FOR SUSPENSION

02239834	LUPRON DEPOT	ABV

22.5MG/VIAL POWDER FOR SUSPENSION

02248240	ELIGARD	SAC
02230248	LUPRON DEPOT	ABV

30MG/VIAL POWDER FOR SUSPENSION

02248999	ELIGARD	SAC
02239833	LUPRON DEPOT	ABV

45MG/VIAL POWDER FOR SUSPENSION

02268892	ELIGARD	SAC

LOMUSTINE

10MG CAPSULE

00360430	CEENU	BMS

40MG CAPSULE

00360422	CEENU	BMS

100MG CAPSULE

00360414	CEENU	BMS

MEGESTROL ACETATE

40MG TABLET

02195917	MEGESTROL	AAP

160MG TABLET

02195925	MEGESTROL	AAP

MELPHALAN

2MG TABLET

00004715	ALKERAN	ASP

MERCAPTOPURINE

50MG TABLET

02415275	MERCAPTOPURINE	RAX
00004723	PURINETHOL	TEV

METHOTREXATE SODIUM

7.5MG SOLUTION

02320029	METOJECT	UNK
02454823	METOJECT SUBCUTANEOUS	UNK

10MG SOLUTION

02320037	METOJECT	UNK
02454831	METOJECT SUBCUTANEOUS	UNK

10MG/0.4ML SOLUTION

02422174	METHOTREXATE	PMS

10MG/ML SOLUTION

02182947	METHOTREXATE	PFI

12.5MG SOLUTION

02454750	METOJECT SUBCUTANEOUS	UNK

15MG SOLUTION

02320045	METOJECT	UNK
02454858	METOJECT SUBCUTANEOUS	UNK

15MG/0.6ML SOLUTION

02422182	METHOTREXATE	PMS

17.5MG SOLUTION

02454769	METOJECT SUBCUTANEOUS	UNK

20MG SOLUTION

02454866	METOJECT SUBCUTANEOUS	UNK

10:00.00 ANTINEOPLASTIC AGENTS

METHOTREXATE SODIUM

20MG/0.8ML SOLUTION

02422190	METHOTREXATE	PMS

22.5MG SOLUTION

02454777	METOJECT SUBCUTANEOUS	UNK

25MG SOLUTION

02454874	METOJECT SUBCUTANEOUS	UNK

25MG/ML SOLUTION

02419173	JAMP-METHOTREXATE	JMP
02099705	METHOTREXATE	TEV
02182777	METHOTREXATE	PFI
02182955	METHOTREXATE	PFI
02398427	METHOTREXATE	SDZ
02417626	METHOTREXATE	MYL
02422166	METHOTREXATE	PMS
02422204	METHOTREXATE	PMS

2.5MG TABLET

02182963	APO-METHOTREXATE	PFI
02170698	PMS-METHOTREXATE	PMS
02244798	RATIO-METHOTREXATE	TEV

10MG TABLET

02182750	METHOTREXATE	PFI

MITOTANE

500MG TABLET

00463221	LYSODREN	BMS

NILUTAMIDE

50MG TABLET

02221861	ANANDRON	SAC

PAZOPANIB

Limited use benefit (prior approval required).

Initial coverage criteria (12 months)
For the first-line treatment of patients with advanced or metastatic clear cell renal carcinoma; AND
Patient has an ECOG performance status of 0 to 2.

Renewal coverage criteria (12 months)
There is no objective evidence of disease progression.

200MG TABLET

02352303	VOTRIENT	NVR

10:00.00 ANTINEOPLASTIC AGENTS

PONATINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Criteria for initial six (6) month coverage:
- For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI therapy; OR
- Treatment of last resort for patients with intolerances or contraindications to imatinib and all other second generation TKI's (dasatinib, nilotinib, bosutinib); OR
- For the treatment of patients with chronic phase chronic myeloid leukemia (CML) who have resistance/disease progression after at least two prior lines of TKI therapy where Iclusig would be available as third-line TKI option; OR
- For the treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy; AND
- An ECOG performance status of 0 to 2.

Note: Second generation TKI's (dasatinib, nilotinib, bosutinib) are not covered as options after ponatinib.

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

15MG TABLET

02437333	ICLUSIG	ARI

45MG TABLET

02437341	ICLUSIG	ARI

PROCARBAZINE HYDROCHLORIDE

50MG CAPSULE

00012750	MATULANE	UNK

RITUXIMAB

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.
- Granulomatosis polyangiitis according to established criteria.
- Microscopic polyangiitis according to established criteria.

(Please refer to Appendix A).

10MG/ML SOLUTION

02241927	RITUXAN	HLR

SUNITINIB MALATE

Limited use benefit (Prior approval required).

Criteria for initial six month coverage of Sutent:
- For patients with histologically proven unresectable or recurrent/metastatic GIST who have failed or are unable to tolerate imatinib therapy.

Sunitinib will not be funded concomitantly with imatinib.

Criteria for assessment at every 12 months:
- There is no objective evidence of disease progression.

12.5MG CAPSULE

02280795	SUTENT	PFI

25MG CAPSULE

02280809	SUTENT	PFI

50MG CAPSULE

02280817	SUTENT	PFI

10:00.00 ANTINEOPLASTIC AGENTS

TAMOXIFEN CITRATE

10MG TABLET

00812404	APO-TAMOX	APX
00851965	TEVA-TAMOXIFEN	TEV

20MG TABLET

00812390	APO-TAMOX	APX
02048485	NOLVADEX-D	AZC
00851973	TEVA-TAMOXIFEN	TEV

TEMOZOLOMIDE

Limited use benefit (prior approval required).

For treatment of adult patients with glioblastoma multiform or anaplastic astrocytoma, and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy).
For treatment of adult patients with newly diagnosed glioblastoma multiform concomitantly with radiotherapy and then as maintenance treatment.

5MG CAPSULE

02441160	ACT TEMOZOLOMIDE	ACG
02443473	TARO-TEMOZOLOMIDE	TAR
02241093	TEMODAL	FRS

20MG CAPSULE

02395274	ACT TEMOZOLOMIDE	ACG
02443481	TARO-TEMOZOLOMIDE	TAR
02241094	TEMODAL	FRS

100MG CAPSULE

02395282	ACT TEMOZOLOMIDE	ACG
02443511	TARO-TEMOZOLOMIDE	TAR
02241095	TEMODAL	FRS

140MG CAPSULE

02395290	ACT TEMOZOLOMIDE	ACG
02413116	APO-TEMOZOLOMIDE	APX
02443538	TARO-TEMOZOLOMIDE	TAR
02312794	TEMODAL	FRS

250MG CAPSULE

02395312	ACT TEMOZOLOMIDE	ACG
02443554	TARO-TEMOZOLOMIDE	TAR
02241096	TEMODAL	FRS

THIOGUANINE

40MG TABLET

00282081	LANVIS	ASP

10:00.00 ANTINEOPLASTIC AGENTS

TRAMETINIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for trametinib (Mekinist):
- For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
- For the first-line treatment of patients with metastatic or unresectable melanoma in combination with dabrafenib(Tafinlar)

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG* performance status of 0 to 1;

*ECOG = European Cooperative Oncology Group Status

AND
- Patient is previously untreated.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

0.5MG TABLET

02409623	MEKINIST	NVR

2MG TABLET

02409658	MEKINIST	NVR

TRETINOIN

10MG CAPSULE

02145839	VESANOID	CHE

TRIPTORELIN PAMOATE

3.75MG/VIAL POWDER FOR SUSPENSION

02240000	TRELSTAR	ALL

11.25MG/VIAL POWDER FOR SUSPENSION

02243856	TRELSTAR	ALL

22.5MG POWDER FOR SUSPENSION

02412322	TRELSTAR	ALL

VEMURAFENIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for vemurafenib (Zelboraf):
For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
For the first-line treatment of patients with metastatic or unresectable melanoma in combination with cobimetinib (Cotellic).

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

ST **240MG TABLET**

02380242	ZELBORAF	HLR

12:00 AUTONOMIC DRUGS

12:04.00 PARASYMPATHOMIMETIC AGENTS

BETHANECHOL CHLORIDE

10MG TABLET

01947958	DUVOID	PAL

25MG TABLET

01947931	DUVOID	PAL

50MG TABLET

01947923	DUVOID	PAL

DONEPEZIL HYDROCHLORIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST **5MG TABLET**

02419866	ACCEL-DONEPEZIL	ACP
02397595	ACT DONEPEZIL	ACG
02362260	APO-DONEPEZIL	APX
02232043	ARICEPT	PFI
02400561	AURO-DONEPEZIL	AUR
02412853	BIO-DONEPEZIL	BMI
02402645	DONEPEZIL	ACC
02416417	DONEPEZIL	PDL
02420597	DONEPEZIL	SIV
02425343	ECL-DONEPEZIL	ECL
02404419	JAMP-DONEPEZIL	JMP
02416948	JAMP-DONEPEZIL	JMP
02402092	MAR-DONEPEZIL	MAR
02359472	MYLAN-DONEPEZIL	MYL
02439557	NAT-DONEPEZIL	NPH
02322331	PMS-DONEPEZIL	PMS
02381508	RAN-DONEPEZIL	RBY
02412918	RIVA-DONEPEZIL	RIV
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02340607	TEVA-DONEPEZIL	TEV

ST **10MG TABLET**

02419874	ACCEL-DONEPEZIL	ACP
02397609	ACT DONEPEZIL	ACG
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI
02400588	AURO-DONEPEZIL	AUR
02412861	BIO-DONEPEZIL	BMI

12:04.00 PARASYMPATHOMIMETIC AGENTS

DONEPEZIL HYDROCHLORIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST **10MG TABLET**

02402653	DONEPEZIL	ACC
02416425	DONEPEZIL	PDL
02420600	DONEPEZIL	SIV
02425351	ECL-DONEPEZIL	ECL
02404427	JAMP-DONEPEZIL	JMP
02416956	JAMP-DONEPEZIL	JMP
02402106	MAR-DONEPEZIL	MAR
02359480	MYLAN-DONEPEZIL	MYL
02439565	NAT-DONEPEZIL	NPH
02322358	PMS-DONEPEZIL	PMS
02381516	RAN-DONEPEZIL	RBY
02412934	RIVA-DONEPEZIL	RIV
02328682	SANDOZ DONEPEZIL	SDZ
02428490	SEPTA DONEPEZIL	SPT
02340615	TEVA-DONEPEZIL	TEV

GALANTAMINE HYDROBROMIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST **8MG CAPSULE (EXTENDED RELEASE)**

02425157	AURO-GALANTAMINE ER	AUR
02443015	GALANTAMINE	SAN
02416573	GALANTAMINE ER	PDL
02420821	MAR-GALANTAMINE ER	MAR

12:04.00 PARASYMPATHOMIMETIC AGENTS

GALANTAMINE HYDROBROMIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST **8MG CAPSULE (EXTENDED RELEASE)**

02339439	MYLAN-GALANTAMINE ER	MYL
02316943	PAT-GALANTAMINE ER	KLA
02398370	PMS-GALANTAMINE ER	PMS
02377950	TEVA-GALANTAMINE ER	TEV

ST **16MG CAPSULE (EXTENDED RELEASE)**

02425165	AURO-GALANTAMINE ER	AUR
02443023	GALANTAMINE	SAN
02416581	GALANTAMINE ER	PDL
02420848	MAR-GALANTAMINE ER	MAR
02339447	MYLAN-GALANTAMINE ER	MYL
02316951	PAT-GALANTAMINE ER	KLA
02398389	PMS-GALANTAMINE ER	PMS
02377969	TEVA-GALANTAMINE ER	TEV

ST **24MG CAPSULE (EXTENDED RELEASE)**

02425173	AURO-GALANTAMINE ER	AUR
02443031	GALANTAMINE	SAN
02416603	GALANTAMINE ER	PDL
02420856	MAR-GALANTAMINE ER	MAR
02339455	MYLAN-GALANTAMINE ER	MYL
02316978	PAT-GALANTAMINE ER	KLA
02398397	PMS-GALANTAMINE ER	PMS
02377977	TEVA-GALANTAMINE ER	TEV

NEOSTIGMINE BROMIDE

ST **15MG TABLET**

00869945	PROSTIGMIN	VAE

PILOCARPINE HYDROCHLORIDE

ST **5MG TABLET**

02402483	PILOCARPINE HYDROCHLORIDE	RAX
02216345	SALAGEN	PFI

PYRIDOSTIGMINE BROMIDE

ST **60MG TABLET**

00869961	MESTINON	VAE

ST **180MG TABLET (EXTENDED RELEASE)**

00869953	MESTINON-SR	VAE

12:04.00 PARASYMPATHOMIMETIC AGENTS

RIVASTIGMINE HYDROGEN TARTRATE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

ST **1.5MG CAPSULE**

02336715	APO-RIVASTIGMINE	APX
02242115	EXELON	NVR
02401614	MED-RIVASTIGMINE	GMP
02305984	NOVO-RIVASTIGMINE	NOP
02306034	PMS-RIVASTIGMINE	PMS
02311283	RATIO-RIVASTIGMINE	TEV
02416999	RIVASTIGMINE	PDL
02324563	SANDOZ RIVASTIGMINE	SDZ

ST **3MG CAPSULE**

02336723	APO-RIVASTIGMINE	APX
02242116	EXELON	NVR
02401622	MED-RIVASTIGMINE	GMP
02305992	NOVO-RIVASTIGMINE	NOP
02306042	PMS-RIVASTIGMINE	PMS
02311291	RATIO-RIVASTIGMINE	TEV
02417006	RIVASTIGMINE	PDL
02324571	SANDOZ RIVASTIGMINE	SDZ

ST **4.5MG CAPSULE**

02336731	APO-RIVASTIGMINE	APX
02242117	EXELON	NVR
02401630	MED-RIVASTIGMINE	GMP
02306018	NOVO-RIVASTIGMINE	NOP
02306050	PMS-RIVASTIGMINE	PMS
02311305	RATIO-RIVASTIGMINE	TEV
02417014	RIVASTIGMINE	PDL
02324598	SANDOZ RIVASTIGMINE	SDZ

ST **6MG CAPSULE**

02336758	APO-RIVASTIGMINE	APX
02242118	EXELON	NVR
02401649	MED-RIVASTIGMINE	GMP
02306026	NOVO-RIVASTIGMINE	NOP
02306069	PMS-RIVASTIGMINE	PMS
02311313	RATIO-RIVASTIGMINE	TEV
02417022	RIVASTIGMINE	PDL
02324601	SANDOZ RIVASTIGMINE	SDZ

ST **2MG/ML SOLUTION**

02245240	EXELON	NVR

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

ACLIDINIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

400MCG POWDER

02409720	TUDORZA GENUAIR	AZC

GLYCOPYRRONIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

50MCG CAPSULE

02394936	SEEBRI BREEZHALER	NVR

HYOSCINE BUTYLBROMIDE

10MG TABLET

00363812	BUSCOPAN	SAC

INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

110MCG & 50MCG CAPSULE

02418282	ULTIBRO BREEZHALER	NVR

IPRATROPIUM BROMIDE

0.03% AEROSOL

02163705	ATROVENT	SAC

0.06% AEROSOL

02163713	ATROVENT	SAC

20MCG/INHALATION AEROSOL

02247686	ATROVENT HFA	BOE

0.03% NASAL SPRAY

02240508	DOM-IPRATROPIUM	DPC
02246083	IPRAVENT	AAP
02239627	PMS-IPRATROPIUM	PMS

0.06% NASAL SPRAY

02246084	IPRAVENT	AAP

125MCG/ML SOLUTION

02231135	PMS-IPRATROPIUM	PMS
02097176	RATIO-IPRATROPIUM UDV	TEV

250MCG/ML SOLUTION

02126222	APO-IPRAVENT	APX
02239131	MYLAN-IPRATROPIUM	MYL
02231136	PMS-IPRATROPIUM	PMS
02231244	PMS-IPRATROPIUM	PMS
02231245	PMS-IPRATROPIUM	PMS

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

IPRATROPIUM BROMIDE

250MCG/ML SOLUTION

99001446	RATIO-IPRATROPIUM	RPH
02097168	RATIO-IPRATROPIUM UDV	TEV
02216221	TEVA-IPRATROPIUM STERINEBS	TEV

IPRATROPIUM BROMIDE, SALBUTAMOL SULFATE

0.2MG & 1MG/ML SOLUTION

02231675	COMBIVENT	BOE
02243789	RATIO-IPRA SAL	TEV
02272695	TEVA-COMBO STERINEBS	TEV

100MCG & 20MCG SOLUTION

02419106	COMBIVENT RESPIMAT	BOE

TIOTROPIUM BROMIDE MONOHYDRATE

Limited use benefit (prior approval required).

For patients with chronic obstructive pulmonary disease (COPD) and who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

18MCG CAPSULE

02246793	SPIRIVA	BOE

2.5MCG SOLUTION

02435381	SPIRIVA RESPIMAT	BOE

TRIMEBUTINE MALEATE

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

100MG TABLET

02349027	AA-TRIMEBUTINE	AAP
02245663	TRIMEBUTINE	AAP

200MG TABLET

02349035	AA-TRIMEBUTINE	AAP
00803499	MODULON	APC
02245664	TRIMEBUTINE	AAP

UMECLIDINIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

62.5MCG POWDER

02423596	INCRUSE ELLIPTA	GSK

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

62.5MCG/25MCG POWDER

02418401	ANORO ELLIPTA	GSK

12:12.04 ALPHA ADRENERGIC AGONISTS

MIDODRINE HYDROCHLORIDE

2.5MG TABLET

02278677	MIDODRINE	AAP

5MG TABLET

02278685	MIDODRINE	AAP

12:12.08 BETA ADRENERGIC AGONISTS

ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- Moderate to severe COPD, as defined by spirometry; AND
- Inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

400MCG & 12MCG POWDER

02439530	DUAKLIR GENUAIR	AZC

FLUTICASONE FUROATE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

100MCG & 25MCG POWDER

02408872	BREO ELLIPTA	GSK

12:12.08 BETA ADRENERGIC AGONISTS

FLUTICASONE FUROATE, VILANTEROL TRIFENATATE (ASTHMA)

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

200MCG & 25MCG POWDER

02444186	BREO ELLIPTA	GSK

FORMOTEROL FUMARATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.
OR
For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

12MCG/CAPSULE CAPSULE

02230898	FORADIL	NVR

FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

6MCG/DOSE POWDER

02237225	OXEZE TURBUHALER	AZC

12MCG/DOSE POWDER

02237224	OXEZE TURBUHALER	AZC

FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

6MCG & 100MCG/INHALATION POWDER

02245385	SYMBICORT 100 TURBUHALER	AZC

6MCG & 200MCG/INHALATION POWDER

02245386	SYMBICORT 200 TURBUHALER	AZC

12:12.08 BETA ADRENERGIC AGONISTS

FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

5MCG & 100MCG/INHALATION AEROSOL

02361752	ZENHALE	FRS

5MCG & 200MCG/INHALATION AEROSOL

02361760	ZENHALE	FRS

5MCG & 50MCG/INHALATION AEROSOL

02361744	ZENHALE	FRS

INDACATEROL MALEATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- are not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist; OR
- have moderate to severe COPD, as defined by spirometry.

75MCG CAPSULE

02376938	ONBREZ BREEZHALER	NVR

OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

2.5MCG & 2.5MCG SOLUTION

02441888	INSPIOLTO RESPIMAT	BOE

ORCIPRENALINE SULFATE

2MG/ML SYRUP

02236783	ORCIPRENALINE	AAP

SALBUTAMOL SULFATE

100MCG/INHALATION AEROSOL

02232570	AIROMIR	VAE
02245669	APO-SALVENT CFC FREE	APX
02326450	NOVO-SALBUTAMOL HFA	TEV
02419858	SALBUTAMOL HFA	SAN
02241497	VENTOLIN HFA	GSK

0.5MG/ML SOLUTION

02208245	PMS-SALBUTAMOL	PMS
02239365	RATIO-SALBUTAMOL	TEV

1MG/ML SOLUTION

02216949	DOM-SALBUTAMOL	DPC
02208229	PMS-SALBUTAMOL	PMS
01986864	RATIO-SALBUTAMOL	TEV
01926934	TEVA-SALBUTAMOL	TEV
02213419	VENTOLIN P.F	GSK

2MG/ML SOLUTION

02208237	PMS-SALBUTAMOL	PMS
02173360	TEVA-SALBUTAMOL	TEV

12:12.08 BETA ADRENERGIC AGONISTS

SALBUTAMOL SULFATE

2MG/ML SOLUTION

02213427	VENTOLIN P.F	GSK

5MG/ML SOLUTION

02139324	DOM-SALBUTAMOL	DPC
00860808	RATIO-SALBUTAMOL	TEV
02213486	VENTOLIN RESPIRATOR	GSK

2MG TABLET

02146843	APO-SALVENT	APX

4MG TABLET

02146851	APO-SALVENT	APX

SALMETEROL XINAFOATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.
OR
For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

50MCG/INHALATION POWDER

02214261	SEREVENT DISKHALER	GSK
02231129	SEREVENT DISKUS	GSK

SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

25MCG & 125MCG AEROSOL

02245126	ADVAIR 125	GSK

25MCG & 250MCG AEROSOL

02245127	ADVAIR 250	GSK

50MCG & 100MCG POWDER

02240835	ADVAIR 100 DISKUS	GSK

50MCG & 250MCG POWDER

02240836	ADVAIR 250 DISKUS	GSK

50MCG & 500MCG POWDER

02240837	ADVAIR 500 DISKUS	GSK

TERBUTALINE SULFATE

500MCG/INHALATION POWDER

00786616	BRICANYL TURBUHALER	AZC

12:12.12 ALPHA AND BETA ADRENERGIC AGONISTS

EPINEPHRINE

0.15MG SOLUTION

02382059	ALLERJECT	KAL

0.3MG SOLUTION

02382067	ALLERJECT	KAL

0.5MG/ML SOLUTION

00578657	EPIPEN JR	MYL

1MG/ML SOLUTION

00155357	ADRENALIN	ERF
00721891	EPINEPHRINE	HOS
00509558	EPIPEN	MYL

12:16.00 SYMPATHOLYTIC AGENTS

DIHYDROERGOTAMINE MESYLATE

1MG/ML LIQUID

00027243	DIHYDROERGOTAMINE	RAX

4MG/ML LIQUID

02228947	MIGRANAL	RAX

12:16.04 ALPHA-ADRENERGIC BLOCKING AGENTS

ALFUZOSIN HYDROCHLORIDE

10MG TABLET (EXTENDED RELEASE)

02414759	ALFUZOSIN	PDL
02447576	ALFUZOSIN	SIV
02315866	APO-ALFUZOSIN	APX
02443201	AURO-ALFUZOSIN	AUR
02304678	SANDOZ ALFUZOSIN	SDZ
02314282	TEVA-ALFUZOSIN PR	TEV
02245565	XATRAL	SAC

TAMSULOSIN HYDROCHLORIDE

0.4MG CAPSULE (SUSTAINED RELEASE)

02294265	RATIO-TAMSULOSIN	TEV
09857334	RATIO-TAMSULOSIN	RPH
02319217	SANDOZ TAMSULOSIN	SDZ
02281392	TEVA-TAMSULOSIN	TEV

0.4MG TABLET (EXTENDED RELEASE)

02362406	APO-TAMSULOSIN	APX
02270102	FLOMAX	BOE
02340208	SANDOZ TAMSULOSIN	SDZ
02413612	TAMSULOSIN	PDL
02427117	TAMSULOSIN	SAN
02429667	TAMSULOSIN	SIV
02368242	TEVA-TAMSULOSIN	TEV

12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For relief of muscle spasm associated with acute, painful musculoskeletal conditions. Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months.

10MG TABLET

02177145	APO-CYCLOBENZAPRINE	APX

12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For relief of muscle spasm associated with acute, painful musculoskeletal conditions. Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months.

10MG TABLET

02348853	AURO-CYCLOBENZAPRINE	AUR
02220644	CYCLOBENZAPRINE	PDL
02287064	CYCLOBENZAPRINE	SAN
02424584	CYCLOBENZAPRINE	SIV
02238633	DOM-CYCLOBENZAPRINE	DPC
02357127	JAMP-CYCLOBENZAPRINE	JMP
02231353	MYLAN-CYCLOBENZAPRINE	MYL
02212048	PMS-CYCLOBENZAPRINE	PMS
02242079	RIVA-CYCLOBENZAPRINE	RIV
02080052	TEVA-CYCLOBENZAPRINE	TEV

TIZANIDINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of spasticity in patients with multiple sclerosis, who have failed therapy with or are intolerant to baclofen.

4MG TABLET

02239170	PAL-TIZANIDINE	PAL
02259893	TIZANIDINE	AAP

12:20.08 DIRECT-ACTING SKELETAL MUSCLE RELAXANTS

DANTROLENE SODIUM

25MG CAPSULE

01997602	DANTRIUM	PPH

12:20.12 GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS

BACLOFEN

10MG TABLET

02139332	APO-BACLOFEN	APX
02152584	BACLOFEN	PDL
02287021	BACLOFEN	SAN
02138271	DOM-BACLOFEN	DPC
00455881	LIORESAL	NVR
02088398	MYLAN-BACLOFEN	MYL
02063735	PMS-BACLOFEN	PMS
02236507	RATIO-BACLOFEN	TEV
02242150	RIVA-BACLOFEN	RIV

20MG TABLET

02139391	APO-BACLOFEN	APX
02152592	BACLOFEN	PDL
02287048	BACLOFEN	SAN
02138298	DOM-BACLOFEN	DPC
00636576	LIORESAL	NVR
02088401	MYLAN-BACLOFEN	MYL
02063743	PMS-BACLOFEN	PMS
02236508	RATIO-BACLOFEN	TEV
02242151	RIVA-BACLOFEN	RIV

12:20.12 GABA-DERIVATIVE SKELETAL MUSCLE RELAXANTS

BACLOFEN

PDIN FOR EXTEMPORANEOUS MIXTURE

99503011	BACLOFEN ORAL LIQUID	UNK

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (GUM)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

ST **2MG GUM**

02091933	NICORETTE GUM	KIM
80015240	RUGBY NICOTINE POLACRILEX GUM	ACG
80000396	THRIVE NICOTINELL GUM	GSK

ST **4MG GUM**

02091941	NICORETTE GUM	KIM
80000118	NICOTINE GUM	PER
80000402	THRIVE NICOTINELL GUM	NVC

NICOTINE (INHALER)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 doses during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

ST **10MG SPRAY**

02241742	NICORETTE INHALER	KIM

NICOTINE (LOZENGE)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

ST **1MG LOZENGE**

80007461	THRIVE NICOTINE LOZENGES	NVC

ST **2MG LOZENGE**

02247347	NICORETTE LOZENGE	KIM
80007464	THRIVE NICOTINE LOZENGES	NVC

ST **4MG LOZENGE**

02247348	NICORETTE LOZENGE	KIM

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (PATCH)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage will be provided for up to the allowable number of patches for one of the following products, during a one-year period. The year starts on the date the first prescription is filled.
The number of patches covered in the one-year period is:
- Habitrol 168 patches; OR
- Nicoderm 140 patches; OR
- Nicotrol 140 patches

Once this quantity has been reached, the client is eligible again for coverage for nicotine patches when one year has elapsed from the day the initial prescription was filled.

ST **5MG PATCH**

02028697	NICOTROL TRANSDERMAL	UNK

ST **7MG PATCH**

01943057	HABITROL	NVC
80044393	TRANSDERMAL NICOTINE	ACG

ST **10MG PATCH**

02029405	NICOTROL TRANSDERMAL	UNK

ST **14MG PATCH**

01943065	HABITROL	NVC
80013549	NICOTINE TRANSDERMAL SYSTEM	ADD
80044392	TRANSDERMAL NICOTINE	ACG

ST **15MG PATCH**

02029413	NICOTROL TRANSDERMAL	UNK

ST **18MG PATCH**

02241227	TRANSDERMAL NICOTINE PATCHDAY	NVC

ST **21MG PATCH**

01943073	HABITROL	NVC
02241228	NICOTINE TRANSDERMAL	NVC
80014250	NICOTINE TRANSDERMAL SYSTEM	ADD
80044389	TRANSDERMAL NICOTINE	ACG

ST **35MG PATCH**

02241226	TRANSDERMAL NICOTINE PATCHDAY	NVC

ST **36MG PATCH**

02093111	NICODERM	KIM

ST **78MG PATCH**

02093138	NICODERM	KIM

ST **114MG PATCH**

02093146	NICODERM	KIM

VARENICLINE TARTRATE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage will be limited to 165 tablets during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for varenicline (Champix®) when one year has elapsed from the day the initial prescription was filled.

ST **0.5MG TABLET**

02291177	CHAMPIX	PFI

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

VARENICLINE TARTRATE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage will be limited to 165 tablets during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for varenicline (Champix®) when one year has elapsed from the day the initial prescription was filled.

0.5MG & 1MG TABLET		
02298309	CHAMPIX STARTER PACK	PFI
1MG TABLET		
02291185	CHAMPIX	PFI

20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS

20:04.04 IRON PREPARATIONS

FERROUS FUMARATE

300MG CAPSULE

02237556	EURO-FER	EUR
00482064	NEO-FER	NEB
01923420	PALAFER	VAE

20MG SUSPENSION

80029822	JAMP-FERROUS FUMARATE	JMP

60MG/ML SUSPENSION

01923439	PALAFER	VAE

300MG/5ML SUSPENSION

02246590	FERRATE	EUR

300MG TABLET

80024544	JAMP FERROUS FUMARATE	JMP
00031089	JAMP-FERROUS FUMARATE	WAM

FERROUS GLUCONATE

300MG TABLET

00545031	APO-FERROUS GLUCONATE	APX
00031097	FERROUS GLUCONATE	JMP
00041157	FERROUS GLUCONATE	ADA
02244532	FERROUS GLUCONATE	PMT
80002426	FERROUS GLUCONATE	WNP
80006316	FERROUS GLUCONATE	GFP
80009681	FERROUS GLUCONATE	WAM
80000435	NOVO-FERROGLUC	NUR

324MG TABLET

00582727	FERROUS GLUCONATE	VTH

FERROUS SULFATE

30MG/ML LIQUID

80008295	JAMP FERROUS SULFATE LIQUID5	JMP

75MG/ML LIQUID

00762954	ENFAMIL FERINSOL	MJO
80008309	JAMP FERROUS SULFATE	JMP

15MG/ML ORAL LIQUID

02237385	FERODAN INFANT DROPS	ODN

30MG/ML ORAL LIQUID

00758469	FERODAN	ODN
00792675	PMS-FERROUS SULFATE	PMS

125MG/ML ORAL LIQUID

00816035	PMS-FERROUS SULFATE	PMS

6MG/ML SOLUTION

00017884	FER-INSYR	MJO
02242863	PEDIAFER	EUR

15MG/ML SOLUTION

02232202	PEDIAFER	EUR
02222574	PMS-FERROUS SULFATE	PMS

60MG TABLET

80012039	IRON	WNP

300MG TABLET

02246733	EURO-FERROUS SULFATE	EUR
02248699	FERODAN	ODN

20:04.04 IRON PREPARATIONS

FERROUS SULFATE

300MG TABLET

00346918	FERROUS SULFATE	PMT
00782114	FERROUS SULFATE	VTH
00031100	JAMP-FERROUS SULFATE	JMP
80057416	M-SULFATE FERREUX	MAN
00586323	PMS-FERROUS SULFATE	PMS

IRON

100MG CAPSULE

80024232	JAMP-FER	JMP

12.5MG/ML LIQUID

02243333	FERRLECIT	SAC

IRON DEXTRAN

50MG/ML LIQUID

02205963	DEXIRON	LUI
02221780	INFUFER	SDZ

IRON SUCROSE

20MG/ML LIQUID

02243716	VENOFER	LUI

PDIN FOR EXTEMPORANEOUS MIXTURE

99506015	IRON SUCROSE STERILE INFUSION	UNK

POLYSACCHARIDE IRON COMPLEX

Limited use benefit (prior approval not required).

For children 12 years of age or under.

15MG POWDER

80033717	FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX	BSY

20:12.04 ANTICOAGULANTS

ACENOCOUMAROL

1MG TABLET

00010383	SINTROM	PAL

4MG TABLET

00010391	SINTROM	PAL

APIXABAN

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

2.5MG TABLET

02377233	ELIQUIS	BMS

20:12.04 ANTICOAGULANTS

APIXABAN

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

ST **5MG TABLET**

02397714	ELIQUIS	BMS

DABIGATRAN ETEXILATE MESILATE

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require dabigatran etexilate for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

ST **110MG CAPSULE**

02312441	PRADAXA	BOE

ST **150MG CAPSULE**

02358808	PRADAXA	BOE

DALTEPARIN SODIUM

2,500IU/0.2ML SOLUTION		
02132621	FRAGMIN	PFI
3,500IU/0.28ML SOLUTION		
02430789	FRAGMIN	PFI
5,000IU/0.2ML SOLUTION		
02132648	FRAGMIN	PFI
7,500IU/0.3ML SOLUTION		
02352648	FRAGMIN	PFI
10,000IU/0.4ML SOLUTION		
02352656	FRAGMIN	PFI
10,000IU/ML SOLUTION		
02132664	FRAGMIN	PFI
12,500IU/0.5ML SOLUTION		
02352664	FRAGMIN	PFI
15,000IU/0.6ML SOLUTION		
02352672	FRAGMIN	PFI
18,000IU/0.72ML SOLUTION		
02352680	FRAGMIN	PFI
25,000IU/ML SOLUTION		
02231171	FRAGMIN	PFI

20:12.04 ANTICOAGULANTS

ENOXAPARIN SODIUM

30MG/0.3ML SOLUTION		
02012472	LOVENOX	SAC
40MG/0.4ML SOLUTION		
02236883	LOVENOX	SAC
60MG/0.6ML SOLUTION		
02378426	LOVENOX	SAC
80MG/0.8ML SOLUTION		
02378434	LOVENOX	SAC
100MG/1ML SOLUTION		
02378442	LOVENOX	SAC
150MG/1.0ML SOLUTION		
02242692	LOVENOX HP	SAC
150MG/ML SOLUTION		
02378469	LOVENOX HP	SAC
300MG/3ML SOLUTION		
02236564	LOVENOX	SAC

HEPARIN SODIUM

100U/ML LIQUID		
00727520	HEPARIN LEO	LEO
1,000U/ML LIQUID		
00453811	HEPARIN LEO	LEO
10 U/ML SOLUTION		
00725323	HEPARIN LOCK FLUSH	HOS
100 U/ML SOLUTION		
00725315	HEPARIN LOCK FLUSH	HOS
1,000 U/ML SOLUTION		
02303086	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	SDZ
10,000 U/ML SOLUTION		
02303108	HEPARIN SODIUM (MULTIDOSE VIAL-WITH PRESERVATIVE)	SDZ
02303094	HEPARIN SODIUM (SINGLE USE VIAL-PRESERVATIVE FREE)	SDZ
10,000U SOLUTION		
02392453	HEPARIN SODIUM	FKD

NADROPARIN CALCIUM

9,500IU/ML SOLUTION		
02236913	FRAXIPARINE	ASP
19,000IU/ML SOLUTION		
02240114	FRAXIPARINE FORTE	ASP

20:12.04 ANTICOAGULANTS

RIVAROXABAN

Limited use benefit (prior approval required).

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) for Stroke Prevention in Atrial Fibrillation (SPAF)
For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require rivaroxaban for the prevention of stroke and systemic embolism AND in whom:

- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation is not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e., no access to INR testing service at a laboratory, clinic, pharmacy, and at home)

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto)
For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE).

ST **10MG TABLET**

02316986	XARELTO	BAY

ST **15MG TABLET**

02378604	XARELTO	BAY

ST **20MG TABLET**

02378612	XARELTO	BAY

TINZAPARIN SODIUM

2,500IU/0.25ML SOLUTION

02229755	INNOHEP	LEO

3,500IU/0.35ML SOLUTION

02358158	INNOHEP	LEO

4,500IU/0.45ML SOLUTION

02358166	INNOHEP	LEO

8,000IU/0.4ML SOLUTION

02429462	INNOHEP	LEO

10,000IU/0.5ML SOLUTION

02231478	INNOHEP	LEO

10,000IU/ML SOLUTION

02167840	INNOHEP	LEO

12,000IU/0.6ML SOLUTION

02429470	INNOHEP	LEO

14,000IU/0.7ML SOLUTION

02358174	INNOHEP	LEO

16,000IU/0.8ML SOLUTION

02429489	INNOHEP	LEO

18,000IU/0.9ML SOLUTION

02358182	INNOHEP	LEO

20,000IU/ML SOLUTION

02229515	INNOHEP	LEO

WARFARIN SODIUM

ST **1MG TABLET**

02242924	APO-WARFARIN	APX
01918311	COUMADIN	BMS
02242680	TARO-WARFARIN	TAR

ST **2MG TABLET**

02242925	APO-WARFARIN	APX
01918338	COUMADIN	BMS
02242681	TARO-WARFARIN	TAR

20:12.04 ANTICOAGULANTS

WARFARIN SODIUM

ST **2.5MG TABLET**

02242926	APO-WARFARIN	APX
01918346	COUMADIN	BMS
02242682	TARO-WARFARIN	TAR

ST **3MG TABLET**

02245618	APO-WARFARIN	APX
02240205	COUMADIN	BMS
02242683	TARO-WARFARIN	TAR

ST **4MG TABLET**

02242927	APO-WARFARIN	APX
02007959	COUMADIN	BMS
02242684	TARO-WARFARIN	TAR

ST **5MG TABLET**

02242928	APO-WARFARIN	APX
01918354	COUMADIN	BMS
02242685	TARO-WARFARIN	TAR

6MG TABLET

02240206	COUMADIN	BMS
02242686	TARO-WARFARIN	TAR

ST **7.5MG TABLET**

02242697	TARO-WARFARIN	TAR

ST **10MG TABLET**

02242929	APO-WARFARIN	APX
01918362	COUMADIN	BMS
02242687	TARO-WARFARIN	TAR

20:12.14 PLATELET AGGREGATION INHIBITORS

ANAGRELIDE HYDROCHLORIDE

ST **0.5MG CAPSULE**

02236859	AGRYLIN	SHI
02274949	PMS-ANAGRELIDE	PMS
02260107	SANDOZ ANAGRELIDE	SDZ

20:12.18 PLATELET AGGREGATION INHIBITORS

CLOPIDOGREL BISULFATE

ST **75MG TABLET**

02303027	ACT CLOPIDOGREL	ACG
02252767	APO-CLOPIDOGREL	APX
02416387	AURO-CLOPIDOGREL	AUR
02385813	CLOPIDOGREL	SIV
02394820	CLOPIDOGREL	PDL
02400553	CLOPIDOGREL	SAN
02378507	DOM-CLOPIDOGREL	DPC
02415550	JAMP-CLOPIDOGREL	JMP
02422255	MAR-CLOPIDOGREL	MAR
02408910	MINT-CLOPIDOGREL	MIN
02351536	MYLAN-CLOPIDOGREL	MYL
02238682	PLAVIX	SAC
02348004	PMS-CLOPIDOGREL	PMS
02379813	RAN-CLOPIDOGREL	RBY
02388529	RIVA-CLOPIDOGREL	RIV
02359316	SANDOZ CLOPIDOGREL	SDZ
02293161	TEVA-CLOPIDOGREL	TEV

20:12.18 PLATELET AGGREGATION INHIBITORS

TICAGRELOR

Limited use benefit (prior approval not required).

For the treatment of Acute Coronary Syndrome, defined as unstable angina or myocardial infarction, when initiated in hospital in consultation with a Specialist in Cardiology, Cardiac Surgery, Cardiovascular & Thoracic Surgery, Internal Medicine or General Surgery. Treatment must be in combination with low dose ASA. Special authorization may be granted for 12 months.

90MG TABLET

02368544	BRILINTA	AZC

TICLOPIDINE HYDROCHLORIDE

250MG TABLET

02236848	TEVA-TICLOPIDINE	TEV
02237701	TICLOPIDINE	AAP

20:16.00 HEMATOPOIETIC AGENTS

FILGRASTIM

300MCG/ML INJECTION

09853464	NEUPOGEN (ON)	AMG
99001454	NEUPOGEN (QC)	AMG

300MCG SOLUTION

02441489	GRASTOFIL	APX

300MCG/ML SOLUTION

01968017	NEUPOGEN	AMG

480MCG SOLUTION

02454548	GRASTOFIL	APX

PEGFILGRASTIM

Limited use benefit (prior approval required).

CHEMOTHERAPY SUPPORT

Primary Prophylaxis
For use in previously untreated patients receiving a moderate to severely myelosuppressive chemotherapy regimen (i.e. ≥40% incidence of febrile neutropenia). Febrile neutropenia is defined as a temperature ≥38.5°C or >38.0°C three times in a 24 hour period and neutropenia with an absolute neutrophil count (ANC) <0.5 x 109/L.

Secondary Prophylaxis
For use in patients receiving myelosuppressive chemotherapy who have experienced an episode of febrile neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; OR
For use in patients who have experienced a dose reduction or treatment delay longer than one week, due to neutropenia.

The recommended dosage of pegfilgrastim is a single subcutaneous injection of 6 mg, administered once per cycle of chemotherapy. Pegfilgrastim should be administered no sooner than 24 hours after the administration of cytotoxic chemotherapy.

10MG/ML SOLUTION

02249790	NEULASTA	AMG

20:16.00 HEMATOPOIETIC AGENTS

PLERIXAFOR

Limited use benefit (prior approval not required).

For use in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation in patients with:
- Non-Hodgkin's lymphoma (NHL); OR
- Multiple myeloma (MM);

AND
- Prescribed by an oncologist or hematologist.

AND if one of the following are met
- A PBCD34+ count of < 10 cells/uL after 4 days of filgrastim; OR
- Less than 50% of the target CD34 yield is achieved on the 1st day of apheresis (after being mobilized with filgrastim alone or following chemotherapy); OR
- If a patient has failed a previous stem cell mobilization with filgrastim alone or following chemotherapy.

Reimbursement is limited to a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt. The dose of Mozobil is limited to a maximum of 40mg per day

20MG SOLUTION

02377225	MOZOBIL	SAC

20:24.00 HEMORRHEOLOGIC AGENTS

PENTOXIFYLLINE

400MG TABLET (EXTENDED RELEASE)

02230090	PENTOXIFYLLINE	AAP

20:28.16 HEMOSTATICS

TRANEXAMIC ACID

500MG TABLET

02064405	CYKLOKAPRON	PFI
02409097	GD-TRANEXAMIC ACID	PFI
02401231	TRANEXAMIC ACID	RAX

PDIN FOR EXTEMPORANEOUS MIXTURE

99503006	TRANEXAMIC DENTAL MOUTHWASH	UNK

24:00 CARDIOVASCULAR DRUGS

24:04.04 ANTIARRHYTHMIC AGENTS

AMIODARONE HYDROCHLORIDE

ST **100MG TABLET**

02292173	PMS-AMIODARONE	PMS

ST **200MG TABLET**

02364336	AMIODARONE	SAN
02385465	AMIODARONE	SIV
02246194	APO-AMIODARONE	APX
02246331	DOM-AMIODARONE	DPC
02240604	MYLAN-AMIODARONE	MYL
02242472	PMS-AMIODARONE	PMS
02309661	PRO-AMIODARONE	PDL
02247217	RIVA-AMIODARONE	RIV
02243836	SANDOZ AMIODARONE	SDZ
02239835	TEVA-AMIODARONE	TEV

ST **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503016	AMIODARONE ORAL LIQUID	UNK

DISOPYRAMIDE

ST **100MG CAPSULE**

02224801	RYTHMODAN	SAC

FLECAINIDE ACETATE

ST **50MG TABLET**

02275538	APO-FLECAINIDE	APX
02459957	AURO-FLECAINIDE	AUR
01966197	TAMBOCOR	VAE

ST **100MG TABLET**

02275546	APO-FLECAINIDE	APX
02459965	AURO-FLECAINIDE	AUR
01966200	TAMBOCOR	VAE

MEXILETINE HYDROCHLORIDE

ST **100MG CAPSULE**

02230359	TEVA-MEXILETINE	TEV

ST **200MG CAPSULE**

02230360	TEVA-MEXILETINE	TEV

PROCAINAMIDE HYDROCHLORIDE

ST **250MG CAPSULE**

00713325	APO-PROCAINAMIDE	APX

ST **375MG CAPSULE**

00713333	APO-PROCAINAMIDE	APX

ST **500MG CAPSULE**

00713341	APO-PROCAINAMIDE	APX

ST **250MG TABLET (EXTENDED RELEASE)**

00638692	PROCAN SR	ERF

PROPAFENONE HYDROCHLORIDE

ST **150MG TABLET**

02243324	APO-PROPAFENONE	APX
02245372	MYLAN-PROPAFENONE	MYL
02294559	PMS-PROPAFENONE	PMS
02343053	PROPAFENONE	SAN
00603708	RYTHMOL	BGP

ST **300MG TABLET**

02243325	APO-PROPAFENONE	APX
02245373	MYLAN-PROPAFENONE	MYL
02294575	PMS-PROPAFENONE	PMS
02343061	PROPAFENONE	SAN
00603716	RYTHMOL	BGP

24:04.08 CARDIOTONIC AGENTS

DIGOXIN

ST **0.05MG/ML SOLUTION**

02242320	TOLOXIN	PED

ST **0.0625MG TABLET**

02335700	TOLOXIN	PED

ST **0.125MG TABLET**

02335719	TOLOXIN	PED

ST **0.250MG TABLET**

02335727	TOLOXIN	PED

24:06.04 BILE ACID SEQUESTRANTS

CHOLESTYRAMINE RESIN

ST **4G POWDER FOR SUSPENSION**

02455609	CHOLESTYRAMINE-ODAN	ODN
00890960	OLESTYR	PMS
02210320	OLESTYR	PMS

COLESEVELAM HYDROCHLORIDE

ST **3.75G POWDER FOR SUSPENSION**

02432463	LODALIS	VAE

ST **625MG TABLET**

02373955	LODALIS	VAE

COLESTIPOL HYDROCHLORIDE

ST **5G GRANULES**

00642975	COLESTID	PFI
02132699	COLESTID ORANGE	PFI

ST **1G TABLET**

02132680	COLESTID	PFI

24:06.05 CHOLESTEROL ABSORPTION INHIBITORS

EZETIMIBE

ST **10MG TABLET**

02414716	ACT EZETIMIBE	ACG
02427826	APO-EZETIMIBE	APX
02422549	EZETIMIBE	PDL
02429659	EZETIMIBE	SIV
02431300	EZETIMIBE	SAN
02247521	EZETROL	FRS
02423235	JAMP-EZETIMIBE	JMP
02422662	MAR-EZETIMIBE	MAR
02423243	MINT-EZETIMIBE	MIN
02416409	PMS-EZETIMIBE	PMS
02425238	PRIVA-EZETIMIBE	PHA
02419548	RAN-EZETIMIBE	RBY
02424436	RIVA-EZETIMIBE	RIV
02416778	SANDOZ EZETIMIBE	SDZ
02354101	TEVA-EZETIMIBE	TEV

24:06.06 FIBRIC ACID DERIVATIVES

BEZAFIBRATE

ST **200MG TABLET**

02240331	PMS-BEZAFIBRATE	PMS

ST **400MG TABLET (EXTENDED RELEASE)**

02083523	BEZALIP SR	ACG
02453312	JAMP-BEZAFIBRATE	JMP

FENOFIBRATE

ST **67MG CAPSULE**

02243180	APO-FENO-MICRO	APX

ST **100MG CAPSULE**

02225980	APO-FENOFIBRATE	APX

ST **160MG CAPSULE**

02250004	FENOMAX	CIP

ST **200MG CAPSULE**

02239864	APO-FENO-MICRO	APX
02240360	FENO-MICRO	PDL
02250039	RATIO-FENOFIBRATE	TEV

ST **48MG TABLET**

02269074	LIPIDIL EZ	BGP
02390698	SANDOZ FENOFIBRATE E	SDZ

ST **100MG TABLET**

02246859	APO-FENO-SUPER	APX
02310228	PRO-FENO-SUPER	PDL
02288044	SANDOZ FENOFIBRATE S	SDZ
02289083	TEVA-FENOFIBRATE-S	TEV

ST **145MG TABLET**

02269082	LIPIDIL EZ	BGP
02465167	MINT-FENOFIBRATE E	MIN
02390701	SANDOZ FENOFIBRATE E	SDZ

ST **160MG TABLET**

02246860	APO-FENO-SUPER	APX
02241602	LIPIDIL SUPRA	BGP
02310236	PRO-FENO-SUPER	PDL
02288052	SANDOZ FENOFIBRATE S	SDZ
02289091	TEVA-FENOFIBRATE-S	TEV

GEMFIBROZIL

ST **300MG CAPSULE**

01979574	APO-GEMFIBROZIL	APX
02241608	DOM-GEMFIBROZIL	DPC
02239951	PMS-GEMFIBROZIL	PMS
02241704	TEVA-GEMFIBROZIL	TEV

ST **600MG TABLET**

01979582	APO-GEMFIBROZIL	APX
02142074	TEVA-GEMFIBROZIL	TEV

24:06.08 HMG-COA REDUCTASE INHIBITORS

ATORVASTATIN CALCIUM

ST **10MG TABLET**

02295261	APO-ATORVASTATIN	APX
02346486	ATORVASTATIN	PDL
02348705	ATORVASTATIN	SAN
02387891	ATORVASTATIN	SIV
02396424	ATORVASTATIN	APX
02411350	ATORVASTATIN-10	SIV

24:06.08 HMG-COA REDUCTASE INHIBITORS

ATORVASTATIN CALCIUM

ST **10MG TABLET**

02407256	AURO-ATORVASTATIN	AUR
02355612	DOM-ATORVASTATIN	DPC
02399482	DOM-ATORVASTATIN	DPC
02391058	JAMP-ATORVASTATIN	JMP
02230711	LIPITOR	PFI
02392933	MYLAN-ATORVASTATIN	MYL
02313448	PMS-ATORVASTATIN	PMS
02399377	PMS-ATORVASTATIN	PMS
02313707	RAN-ATORVASTATIN	RBY
02350297	RATIO-ATORVASTATIN	TEV
02417936	REDDY-ATORVASTATIN	REC
02422751	RIVA-ATORVASTATIN	RIV
02324946	SANDOZ ATORVASTATIN	SDZ
02310899	TEVA-ATORVASTATIN	TEV

ST **20MG TABLET**

02295288	APO-ATORVASTATIN	APX
02346494	ATORVASTATIN	PDL
02348713	ATORVASTATIN	SAN
02387905	ATORVASTATIN	SIV
02396432	ATORVASTATIN	APX
02411369	ATORVASTATIN-20	SIV
02407264	AURO-ATORVASTATIN	AUR
02355620	DOM-ATORVASTATIN	DPC
02399490	DOM-ATORVASTATIN	DPC
02391066	JAMP-ATORVASTATIN	JMP
02230713	LIPITOR	PFI
02392941	MYLAN-ATORVASTATIN	MYL
02313456	PMS-ATORVASTATIN	PMS
02399385	PMS-ATORVASTATIN	PMS
02313715	RAN-ATORVASTATIN	RBY
02350319	RATIO-ATORVASTATIN	TEV
02417944	REDDY-ATORVASTATIN	REC
02422778	RIVA-ATORVASTATIN	RIV
02324954	SANDOZ ATORVASTATIN	SDZ
02310902	TEVA-ATORVASTATIN	TEV

ST **40MG TABLET**

02295296	APO-ATORVASTATIN	APX
02346508	ATORVASTATIN	PDL
02348721	ATORVASTATIN	SAN
02387913	ATORVASTATIN	SIV
02396440	ATORVASTATIN	APX
02411377	ATORVASTATIN-40	SIV
02407272	AURO-ATORVASTATIN	AUR
02355639	DOM-ATORVASTATIN	DPC
02399504	DOM-ATORVASTATIN	DPC
02391074	JAMP-ATORVASTATIN	JMP
02230714	LIPITOR	PFI
02392968	MYLAN-ATORVASTATIN	MYL
02313464	PMS-ATORVASTATIN	PMS
02399393	PMS-ATORVASTATIN	PMS
02313723	RAN-ATORVASTATIN	RBY
02350327	RATIO-ATORVASTATIN	TEV
02417952	REDDY-ATORVASTATIN	REC

24:06.08 HMG-COA REDUCTASE INHIBITORS

ATORVASTATIN CALCIUM

40MG TABLET

02422786	RIVA-ATORVASTATIN	RIV
02324962	SANDOZ ATORVASTATIN	SDZ
02310910	TEVA-ATORVASTATIN	TEV

80MG TABLET

02295318	APO-ATORVASTATIN	APX
02346516	ATORVASTATIN	PDL
02348748	ATORVASTATIN	SAN
02387921	ATORVASTATIN	SIV
02396459	ATORVASTATIN	APX
02411385	ATORVASTATIN-80	SIV
02407280	AURO-ATORVASTATIN	AUR
02391082	JAMP-ATORVASTATIN	JMP
02243097	LIPITOR	PFI
02392976	MYLAN-ATORVASTATIN	MYL
02313472	PMS-ATORVASTATIN	PMS
02399407	PMS-ATORVASTATIN	PMS
02313758	RAN-ATORVASTATIN	RBY
02350335	RATIO-ATORVASTATIN	TEV
02417960	REDDY-ATORVASTATIN	REC
02422794	RIVA-ATORVASTATIN	RIV
02324970	SANDOZ ATORVASTATIN	SDZ
02310929	TEVA-ATORVASTATIN	TEV

FLUVASTATIN SODIUM

20MG CAPSULE

02061562	LESCOL	NVR
02400235	SANDOZ FLUVASTATIN	SDZ
02299224	TEVA-FLUVASTATIN	TEV

40MG CAPSULE

02061570	LESCOL	NVR
02400243	SANDOZ FLUVASTATIN	SDZ
02299232	TEVA-FLUVASTATIN	TEV

80MG TABLET (EXTENDED RELEASE)

02250527	LESCOL XL	NVR

LOVASTATIN

20MG TABLET

02248572	ACT LOVASTATIN	ACG
02220172	APO-LOVASTATIN	APX
02353229	LOVASTATIN	SAN
02246013	PMS-LOVASTATIN	PMS
02312670	PRO-LOVASTATIN	PDL
02272288	RIVA-LOVASTATIN	RIV
02247056	SANDOZ LOVASTATIN	SDZ
02246542	TEVA-LOVASTATIN	TEV

40MG TABLET

02248573	ACT LOVASTATIN	ACG
02220180	APO-LOVASTATIN	APX
02353237	LOVASTATIN	SAN
02246014	PMS-LOVASTATIN	PMS
02312689	PRO-LOVASTATIN	PDL
02272296	RIVA-LOVASTATIN	RIV
02247057	SANDOZ LOVASTATIN	SDZ
02246543	TEVA-LOVASTATIN	TEV

24:06.08 HMG-COA REDUCTASE INHIBITORS

PRAVASTATIN SODIUM

10MG TABLET

02248182	ACT PRAVASTATIN	ACG
02243506	APO-PRAVASTATIN	APX
02249723	DOM-PRAVASTATIN	DPC
02330954	JAMP-PRAVASTATIN	JMP
02317451	MINT-PRAVASTATIN	MIN
02247655	PMS-PRAVASTATIN	PMS
02356546	PRAVASTATIN	SAN
02389703	PRAVASTATIN	SIV
02243824	PRAVASTATIN-10	PDL
02284421	RAN-PRAVASTATIN	RBY
02270234	RIVA-PRAVASTATIN	RIV
02247008	TEVA-PRAVASTATIN	TEV

20MG TABLET

02248183	ACT PRAVASTATIN	ACG
02243507	APO-PRAVASTATIN	APX
02249731	DOM-PRAVASTATIN	DPC
02330962	JAMP-PRAVASTATIN	JMP
02317478	MINT-PRAVASTATIN	MIN
02247656	PMS-PRAVASTATIN	PMS
00893757	PRAVACHOL	BMS
02356554	PRAVASTATIN	SAN
02389738	PRAVASTATIN	SIV
02243825	PRAVASTATIN-20	PDL
02284448	RAN-PRAVASTATIN	RBY
02270242	RIVA-PRAVASTATIN	RIV
02247009	TEVA-PRAVASTATIN	TEV

40MG TABLET

02248184	ACT PRAVASTATIN	ACG
02243508	APO-PRAVASTATIN	APX
02249758	DOM-PRAVASTATIN	DPC
02330970	JAMP-PRAVASTATIN	JMP
02317486	MINT-PRAVASTATIN	MIN
02247657	PMS-PRAVASTATIN	PMS
02222051	PRAVACHOL	BMS
02356562	PRAVASTATIN	SAN
02389746	PRAVASTATIN	SIV
02243826	PRAVASTATIN-40	PDL
02284456	RAN-PRAVASTATIN	RBY
02270250	RIVA-PRAVASTATIN	RIV
02247010	TEVA-PRAVASTATIN	TEV

ROSUVASTATIN CALCIUM

5MG TABLET

02339765	ACT ROSUVASTATIN	ACG
02337975	APO-ROSUVASTATIN	APX
02442574	AURO-ROSUVASTATIN	AUR
02265540	CRESTOR	AZC
02386704	DOM-ROSUVASTATIN	DPC
02391252	JAMP-ROSUVASTATIN	JMP
02413051	MAR-ROSUVASTATIN	MAR
02399164	MED-ROSUVASTATIN	GMP
02397781	MINT-ROSUVASTATIN	MIN
02381265	MYLAN-ROSUVASTATIN	MYL

24:06.08 HMG-COA REDUCTASE INHIBITORS

ROSUVASTATIN CALCIUM

ST **5MG TABLET**

02378523	PMS-ROSUVASTATIN	PMS
02382644	RAN-ROSUVASTATIN	RBY
02380013	RIVA-ROSUVASTATIN	RIV
02381176	ROSUVASTATIN	PDL
02389037	ROSUVASTATIN	SIV
02405628	ROSUVASTATIN	SAN
02411628	ROSUVASTATIN-5	SIV
02338726	SANDOZ ROSUVASTATIN	SDZ
02354608	TEVA-ROSUVASTATIN	TEV

ST **10MG TABLET**

02339773	ACT ROSUVASTATIN	ACG
02337983	APO-ROSUVASTATIN	APX
02442582	AURO-ROSUVASTATIN	AUR
02247162	CRESTOR	AZC
02386712	DOM-ROSUVASTATIN	DPC
02391260	JAMP-ROSUVASTATIN	JMP
02413078	MAR-ROSUVASTATIN	MAR
02399172	MED-ROSUVASTATIN	GMP
02397803	MINT-ROSUVASTATIN	MIN
02381273	MYLAN-ROSUVASTATIN	MYL
02378531	PMS-ROSUVASTATIN	PMS
02382652	RAN-ROSUVASTATIN	RBY
02380056	RIVA-ROSUVASTATIN	RIV
02381184	ROSUVASTATIN	PDL
02389045	ROSUVASTATIN	SIV
02405636	ROSUVASTATIN	SAN
02411636	ROSUVASTATIN-10	SIV
02338734	SANDOZ ROSUVASTATIN	SDZ
02354616	TEVA-ROSUVASTATIN	TEV

ST **20MG TABLET**

02339781	ACT ROSUVASTATIN	ACG
02337991	APO-ROSUVASTATIN	APX
02442590	AURO-ROSUVASTATIN	AUR
02247163	CRESTOR	AZC
02386720	DOM-ROSUVASTATIN	DPC
02391279	JAMP-ROSUVASTATIN	JMP
02413086	MAR-ROSUVASTATIN	MAR
02399180	MED-ROSUVASTATIN	GMP
02397811	MINT-ROSUVASTATIN	MIN
02381281	MYLAN-ROSUVASTATIN	MYL
02378558	PMS-ROSUVASTATIN	PMS
02382660	RAN-ROSUVASTATIN	RBY
02380064	RIVA-ROSUVASTATIN	RIV
02381192	ROSUVASTATIN	PDL
02389053	ROSUVASTATIN	SIV
02405644	ROSUVASTATIN	SAN
02411644	ROSUVASTATIN-20	SIV
02338742	SANDOZ ROSUVASTATIN	SDZ
02354624	TEVA-ROSUVASTATIN	TEV

ST **40MG TABLET**

02339803	ACT ROSUVASTATIN	ACG
02338009	APO-ROSUVASTATIN	APX
02442604	AURO-ROSUVASTATIN	AUR

24:06.08 HMG-COA REDUCTASE INHIBITORS

ROSUVASTATIN CALCIUM

ST **40MG TABLET**

02247164	CRESTOR	AZC
02391287	JAMP-ROSUVASTATIN	JMP
02413108	MAR-ROSUVASTATIN	MAR
02399199	MED-ROSUVASTATIN	GMP
02397838	MINT-ROSUVASTATIN	MIN
02381303	MYLAN-ROSUVASTATIN	MYL
02378566	PMS-ROSUVASTATIN	PMS
02382679	RAN-ROSUVASTATIN	RBY
02380102	RIVA-ROSUVASTATIN	RIV
02381206	ROSUVASTATIN	PDL
02389061	ROSUVASTATIN	SIV
02405652	ROSUVASTATIN	SAN
02411652	ROSUVASTATIN-40	SIV
02338750	SANDOZ ROSUVASTATIN	SDZ
02354632	TEVA-ROSUVASTATIN	TEV

SIMVASTATIN

ST **5MG TABLET**

02248103	ACT SIMVASTATIN	ACG
02247011	APO-SIMVASTATIN	APX
02405148	AURO-SIMVASTATIN	AUR
02253747	DOM-SIMVASTATIN	DPC
02281619	DOM-SIMVASTATIN	DPC
02375591	JAMP-SIMVASTATIN	JMP
02375036	MAR-SIMVASTATIN	MAR
02372932	MINT-SIMVASTATIN	MIN
02246582	MYLAN-SIMVASTATIN	MYL
02269252	PMS-SIMVASTATIN	PMS
02329131	RAN-SIMVASTATIN	RBY
02247297	RIVA-SIMVASTATIN	RIV
02247827	SANDOZ SIMVASTATIN	SDZ
02284723	SIMVASTATIN	SAN
02386291	SIMVASTATIN	SIV
02250144	TEVA-SIMVASTATIN	TEV

ST **10MG TABLET**

02248104	ACT SIMVASTATIN	ACG
02247012	APO-SIMVASTATIN	APX
02405156	AURO-SIMVASTATIN	AUR
02253755	DOM-SIMVASTATIN	DPC
02281627	DOM-SIMVASTATIN	DPC
02375605	JAMP-SIMVASTATIN	JMP
02375044	MAR-SIMVASTATIN	MAR
02372940	MINT-SIMVASTATIN	MIN
02246583	MYLAN-SIMVASTATIN	MYL
02269260	PMS-SIMVASTATIN	PMS
02329158	RAN-SIMVASTATIN	RBY
02247298	RIVA-SIMVASTATIN	RIV
02247828	SANDOZ SIMVASTATIN	SDZ
02284731	SIMVASTATIN	SAN
02386305	SIMVASTATIN	SIV
02247221	SIMVASTATIN-10	PDL
02250152	TEVA-SIMVASTATIN	TEV
00884332	ZOCOR	FRS

24:06.08 HMG-COA REDUCTASE INHIBITORS

SIMVASTATIN

20MG TABLET

02248105	ACT SIMVASTATIN	ACG
02247013	APO-SIMVASTATIN	APX
02405164	AURO-SIMVASTATIN	AUR
02253763	DOM-SIMVASTATIN	DPC
02281635	DOM-SIMVASTATIN	DPC
02375613	JAMP-SIMVASTATIN	JMP
02375052	MAR-SIMVASTATIN	MAR
02372959	MINT-SIMVASTATIN	MIN
02246737	MYLAN-SIMVASTATIN	MYL
02269279	PMS-SIMVASTATIN	PMS
02329166	RAN-SIMVASTATIN	RBY
02247299	RIVA-SIMVASTATIN	RIV
02247830	SANDOZ SIMVASTATIN	SDZ
02284758	SIMVASTATIN	SAN
02386313	SIMVASTATIN	SIV
02247222	SIMVASTATIN-20	PDL
02250160	TEVA-SIMVASTATIN	TEV
00884340	ZOCOR	FRS

40MG TABLET

02248106	ACT SIMVASTATIN	ACG
02247014	APO-SIMVASTATIN	APX
02405172	AURO-SIMVASTATIN	AUR
02253771	DOM-SIMVASTATIN	DPC
02281643	DOM-SIMVASTATIN	DPC
02375621	JAMP-SIMVASTATIN	JMP
02375060	MAR-SIMVASTATIN	MAR
02372967	MINT-SIMVASTATIN	MIN
02246584	MYLAN-SIMVASTATIN	MYL
02269287	PMS-SIMVASTATIN	PMS
02329174	RAN-SIMVASTATIN	RBY
02247300	RIVA-SIMVASTATIN	RIV
02247831	SANDOZ SIMVASTATIN	SDZ
02284766	SIMVASTATIN	SAN
02386321	SIMVASTATIN	SIV
02247223	SIMVASTATIN-40	PDL
02250179	TEVA-SIMVASTATIN	TEV
00884359	ZOCOR	FRS

80MG TABLET

02248107	ACT SIMVASTATIN	ACG
02247015	APO-SIMVASTATIN	APX
02405180	AURO-SIMVASTATIN	AUR
02253798	DOM-SIMVASTATIN	DPC
02281651	DOM-SIMVASTATIN	DPC
02375648	JAMP-SIMVASTATIN	JMP
02375079	MAR-SIMVASTATIN	MAR
02372975	MINT-SIMVASTATIN	MIN
02246585	MYLAN-SIMVASTATIN	MYL
02269295	PMS-SIMVASTATIN	PMS
02329182	RAN-SIMVASTATIN	RBY
02247301	RIVA-SIMVASTATIN	RIV
02247833	SANDOZ SIMVASTATIN	SDZ
02284774	SIMVASTATIN	SAN
02386348	SIMVASTATIN	SIV
02247224	SIMVASTATIN-80	PDL
02250187	TEVA-SIMVASTATIN	TEV

24:08.16 CENTRAL ALPHA-AGONISTS

CLONIDINE HYDROCHLORIDE

0.025MG TABLET

02304163	TEVA-CLONIDINE	TEV

0.1MG TABLET

02462192	MINT-CLONIDINE	MIN
02046121	TEVA-CLONIDINE	TEV

0.2MG TABLET

00868957	APO-CLONIDINE	APX
02462206	MINT-CLONIDINE	MIN
02046148	TEVA-CLONIDINE	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503021	CLONIDINE ORAL LIQUID	UNK

METHYLDOPA

125MG TABLET

00360252	METHYLDOPA	AAP

250MG TABLET

00360260	METHYLDOPA	AAP

500MG TABLET

00426830	METHYLDOPA	AAP

METHYLDOPA, HYDROCHLOROTHIAZIDE

250MG & 15MG TABLET

00441708	APO METHAZIDE	APX

250MG & 25MG TABLET

00441716	APO METHAZIDE	APX

24:08.20 DIRECT VASODILATORS

DIAZOXIDE

100MG CAPSULE

00503347	PROGLYCEM	FRS

HYDRALAZINE HYDROCHLORIDE

10MG TABLET

00441619	APO-HYDRALAZINE	APX
02457865	JAMP-HYDRALAZINE	JMP

25MG TABLET

00441627	APO-HYDRALAZINE	APX
02457873	JAMP-HYDRALAZINE	JMP

50MG TABLET

00441635	APO-HYDRALAZINE	APX
02457881	JAMP-HYDRALAZINE	JMP

MINOXIDIL

2.5MG TABLET

00514497	LONITEN	PFI

10MG TABLET

00514500	LONITEN	PFI

24:12.08 NITRATES AND NITRITES

ISOSORBIDE DINITRATE

5MG TABLET

00670944	ISDN	AAP

10MG TABLET

00441686	ISDN	AAP
00786667	PMS-ISOSORBIDE	PMS

30MG TABLET

00441694	ISDN	AAP

ISOSORBIDE-5-MONONITRATE

60MG TABLET (EXTENDED RELEASE)

02272830	APO-ISMN	APX
02126559	IMDUR	AZC
02301288	PMS-ISMN	PMS
02311321	PRO-ISMN	PDL

NITROGLYCERIN

2% OINTMENT

01926454	NITROL	PAL

0.2MG PATCH

02162806	MINITRAN	VAE
02407442	MYLAN-NITRO	MYL
01911910	NITRO-DUR	FRS
00584223	TRANSDERM-NITRO	NVR
02230732	TRINIPATCH	PAL

0.4MG PATCH

02163527	MINITRAN	VAE
02407450	MYLAN-NITRO	MYL
01911902	NITRO-DUR	FRS
00852384	TRANSDERM-NITRO	NVR
02230733	TRINIPATCH	PAL

0.6MG PATCH

02163535	MINITRAN	VAE
02407469	MYLAN-NITRO	MYL
01911929	NITRO-DUR	FRS
02046156	TRANSDERM-NITRO	NVR
02230734	TRINIPATCH	PAL

0.8MG PATCH

02407477	MYLAN-NITRO	MYL
02011271	NITRO-DUR	FRS

0.4MG PUMP

02393433	APO-NITROGLYCERIN	APX
02243588	MYLAN-NITRO	MYL
02231441	NITROLINGUAL PUMPSPRAY	SAC
02238998	RHO-NITRO PUMPSPRAY	SDZ

0.3MG TABLET

00037613	NITROSTAT	PFI

0.6MG TABLET

00037621	NITROSTAT	PFI

24:12.12 PHOSPHODIESTERASE INHIBITORS

SILDENAFIL CITRATE

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization.

20MG TABLET

02418118	APO-SILDENAFIL R	APX
02412179	PMS-SILDENAFIL R	PMS
02279401	REVATIO	PFI
02319500	TEVA-SILDENAFIL R	TEV

TADALAFIL

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization.

20MG TABLET

02338327	ADCIRCA	LIL
02421933	APO-TADALAFIL PAH	APX

24:12.92 MISCELLANEOUS VASODILATING AGENTS

AMBRISENTAN

Limited use benefit (prior approval required).

Maximum dose covered is 10 mg once daily.

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

5MG TABLET

02307065	VOLIBRIS	GSK

10MG TABLET

02307073	VOLIBRIS	GSK

24:12.92 MISCELLANEOUS VASODILATING AGENTS

BOSENTAN MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice daily

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND

- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

62.5MG TABLET

02386194	ACT BOSENTAN	ACG
02399202	APO-BOSENTAN	APX
02383497	MYLAN-BOSENTAN	MYL
02383012	PMS-BOSENTAN	PMS
02386275	SANDOZ BOSENTAN	SDZ
02398400	TEVA-BOSENTAN	TEV
02244981	TRACLEER	ACN

125MG TABLET

02386208	ACT BOSENTAN	ACG
02383500	MYLAN-BOSENTAN	MYL
02383020	PMS-BOSENTAN	PMS
02386283	SANDOZ BOSENTAN	SDZ
02244982	TRACLEER	ACN

DIPYRIDAMOLE

25MG TABLET

00895644	APO-DIPYRIDAMOLE	APX

50MG TABLET

00571245	APO-DIPYRIDAMOLE	APX
00895652	APO-DIPYRIDAMOLE	APX

75MG TABLET

00601845	APO-DIPYRIDAMOLE	APX
00895660	APO-DIPYRIDAMOLE	APX

DIPYRIDAMOLE, ACETYLSALICYLIC ACID

200MG & 25MG CAPSULE

02242119	AGGRENOX	BOE

24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

1MG TABLET

02240588	APO-DOXAZOSIN	APX
01958100	CARDURA-1	PFI
02244527	PMS-DOXAZOSIN	PMS
02242728	TEVA-DOXAZOSIN	TEV

2MG TABLET

02240589	APO-DOXAZOSIN	APX
01958097	CARDURA-2	PFI
02244528	PMS-DOXAZOSIN	PMS
02242729	TEVA-DOXAZOSIN	TEV

4MG TABLET

02240590	APO-DOXAZOSIN	APX

24:20.00 ALPHA ADRENERGIC BLOCKING AGENTS

DOXAZOSIN MESYLATE

4MG TABLET

01958119	CARDURA-4	PFI
02244529	PMS-DOXAZOSIN	PMS
02242730	TEVA-DOXAZOSIN	TEV

PRAZOSIN HYDROCHLORIDE

1MG TABLET

00882801	APO-PRAZO	APX
00560952	MINIPRESS	ERF
01934198	TEVA-PRAZOSIN	TEV

2MG TABLET

00882828	APO-PRAZO	APX
00560960	MINIPRESS	ERF
01934201	TEVA-PRAZOSIN	TEV

5MG TABLET

00882836	APO-PRAZO	APX
00560979	MINIPRESS	ERF
01934228	TEVA-PRAZOSIN	TEV

TERAZOSIN HYDROCHLORIDE

1MG TABLET

02234502	APO-TERAZOSIN	APX
02243746	DOM-TERAZOSIN	DPC
02243518	PMS-TERAZOSIN	PMS
02237476	TERAZOSIN	PDL
02350475	TERAZOSIN	SAN
02230805	TEVA-TERAZOSIN	TEV

2MG TABLET

02234503	APO-TERAZOSIN	APX
02243747	DOM-TERAZOSIN	DPC
02243519	PMS-TERAZOSIN	PMS
02237477	TERAZOSIN	PDL
02350483	TERAZOSIN	SAN
02230806	TEVA-TERAZOSIN	TEV

5MG TABLET

02234504	APO-TERAZOSIN	APX
02243748	DOM-TERAZOSIN	DPC
02243520	PMS-TERAZOSIN	PMS
02237478	TERAZOSIN	PDL
02350491	TERAZOSIN	SAN
02230807	TEVA-TERAZOSIN	TEV

10MG TABLET

02234505	APO-TERAZOSIN	APX
02243749	DOM-TERAZOSIN	DPC
02243521	PMS-TERAZOSIN	PMS
02237479	TERAZOSIN	PDL
02350505	TERAZOSIN	SAN
02230808	TEVA-TERAZOSIN	TEV

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HYDROCHLORIDE

100MG TABLET

02164396	ACEBUTOLOL	PDL
02286246	ACEBUTOLOL	SAN

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

ACEBUTOLOL HYDROCHLORIDE

100MG TABLET

02147602	APO-ACEBUTOLOL	APX
02237721	MYLAN-ACEBUTOLOL	MYL
02237885	MYLAN-ACEBUTOLOL (TYPE S)	MYL
01926543	SECTRAL	SAC
02204517	TEVA-ACEBUTOLOL	TEV

200MG TABLET

02164418	ACEBUTOLOL	PDL
02286254	ACEBUTOLOL	SAN
02147610	APO-ACEBUTOLOL	APX
02237722	MYLAN-ACEBUTOLOL	MYL
01926551	SECTRAL	SAC
02204525	TEVA-ACEBUTOLOL	TEV

400MG TABLET

02164426	ACEBUTOLOL	PDL
02286262	ACEBUTOLOL	SAN
02147629	APO-ACEBUTOLOL	APX
02237723	MYLAN-ACEBUTOLOL	MYL
02204533	TEVA-ACEBUTOLOL	TEV

ATENOLOL

25MG TABLET

02247182	ATENOLOL	SIV
02326701	ATENOLOL	PDL
02392194	BIO-ATENOLOL	BMI
02367556	JAMP-ATENOLOL	JMP
02371979	MAR-ATENOLOL	MAR
02368013	MINT-ATENOL	MIN
02303647	MYLAN-ATENOLOL	MYL
02246581	PMS-ATENOLOL	PMS
02373963	RAN-ATENOLOL	RBY
02277379	RIVA-ATENOLOL	RIV
02368633	SEPTA-ATENOLOL	SPT
02266660	TEVA-ATENOLOL	TEV

50MG TABLET

02255545	ACT ATENOLOL	ACG
00773689	APO-ATENOL	APX
00828807	ATENOLOL	PDL
02238316	ATENOLOL	SIV
02466465	ATENOLOL	SAN
02392178	BIO-ATENOLOL	BMI
02229467	DOM-ATENOLOL	DPC
02367564	JAMP-ATENOLOL	JMP
02371987	MAR-ATENOLOL	MAR
02368021	MINT-ATENOL	MIN
02146894	MYLAN-ATENOLOL	MYL
02237600	PMS-ATENOLOL	PMS
02267985	RAN-ATENOLOL	RBY
02242094	RIVA-ATENOLOL	RIV
02368641	SEPTA-ATENOLOL	SPT
02039532	TENORMIN	AZC
02171791	TEVA-ATENOLOL	TEV

100MG TABLET

02255553	ACT ATENOLOL	ACG
00773697	APO-ATENOL	APX
00828793	ATENOLOL	PDL
02238318	ATENOLOL	SIV
02392186	BIO-ATENOLOL	BMI
02229468	DOM-ATENOLOL	DPC
02367572	JAMP-ATENOLOL	JMP
02371995	MAR-ATENOLOL	MAR
02368048	MINT-ATENOL	MIN
02147432	MYLAN-ATENOLOL	MYL
02237601	PMS-ATENOLOL	PMS
02267993	RAN-ATENOLOL	RBY
02242093	RIVA-ATENOLOL	RIV
02368668	SEPTA-ATENOLOL	SPT
02039540	TENORMIN	AZC
02171805	TEVA-ATENOLOL	TEV

ATENOLOL, CHLORTHALIDONE

50MG & 25MG TABLET

02248763	APO-ATENIDONE	APX
02049961	TENORETIC	AZC
02302918	TEVA-ATENOLOL/CHLORTHALIDONE	TEV

100MG & 25MG TABLET

02248764	APO-ATENIDONE	APX
02049988	TENORETIC	AZC
02302926	TEVA-ATENOLOL/CHLORTHALIDONE	TEV

BISOPROLOL FUMARATE

5MG TABLET

02256134	APO-BISOPROLOL	APX
02383055	BISOPROLOL	SIV
02391589	BISOPROLOL	SAN
02302632	PMS-BISOPROLOL	PMS
02306999	PRO-BISOPROLOL	PDL
02247439	SANDOZ BISOPROLOL	SDZ
02267470	TEVA-BISOPROLOL	TEV

10MG TABLET

02256177	APO-BISOPROLOL	APX
02383063	BISOPROLOL	SIV
02391597	BISOPROLOL	SAN
02302640	PMS-BISOPROLOL	PMS
02307006	PRO-BISOPROLOL	PDL
02247440	SANDOZ BISOPROLOL	SDZ
02267489	TEVA-BISOPROLOL	TEV

CARVEDILOL

3.125MG TABLET

02247933	APO-CARVEDILOL	APX
02418495	AURO-CARVEDILOL	AUR
02248752	CARVEDILOL	SIV
02324504	CARVEDILOL	PDL
02364913	CARVEDILOL	SAN
02248748	DOM-CARVEDILOL	DPC
02368897	JAMP-CARVEDILOL	JMP

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

CARVEDILOL

3.125MG TABLET

02347512	MYLAN-CARVEDILOL	MYL
02245914	PMS-CARVEDILOL	PMS
02268027	RAN-CARVEDILOL	RBY
02252309	RATIO-CARVEDILOL	TEV

6.25MG TABLET

02247934	APO-CARVEDILOL	APX
02418509	AURO-CARVEDILOL	AUR
02248753	CARVEDILOL	SIV
02324512	CARVEDILOL	PDL
02364921	CARVEDILOL	SAN
02248749	DOM-CARVEDILOL	DPC
02368900	JAMP-CARVEDILOL	JMP
02347520	MYLAN-CARVEDILOL	MYL
02245915	PMS-CARVEDILOL	PMS
02268035	RAN-CARVEDILOL	RBY
02252317	RATIO-CARVEDILOL	TEV

12.5MG TABLET

02247935	APO-CARVEDILOL	APX
02418517	AURO-CARVEDILOL	AUR
02248754	CARVEDILOL	SIV
02324520	CARVEDILOL	PDL
02364948	CARVEDILOL	SAN
02248750	DOM-CARVEDILOL	DPC
02368919	JAMP-CARVEDILOL	JMP
02347555	MYLAN-CARVEDILOL	MYL
02245916	PMS-CARVEDILOL	PMS
02268043	RAN-CARVEDILOL	RBY
02252325	RATIO-CARVEDILOL	TEV

25MG TABLET

02247936	APO-CARVEDILOL	APX
02418525	AURO-CARVEDILOL	AUR
02248755	CARVEDILOL	SIV
02324539	CARVEDILOL	PDL
02364956	CARVEDILOL	SAN
02248751	DOM-CARVEDILOL	DPC
02368927	JAMP-CARVEDILOL	JMP
02245917	PMS-CARVEDILOL	PMS
02268051	RAN-CARVEDILOL	RBY
02252333	RATIO-CARVEDILOL	TEV

HYDROCHLOROTHIAZIDE, PINDOLOL

10MG & 25MG TABLET

00568627	VISKAZIDE	TPC

10MG & 50MG TABLET

00568635	VISKAZIDE	TPC

LABETALOL HYDROCHLORIDE

100MG TABLET

02106272	TRANDATE	PAL

200MG TABLET

02106280	TRANDATE	PAL

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

METOPROLOL TARTRATE

25MG TABLET

02246010	APO-METOPROLOL	APX
02252252	DOM-METOPROLOL-L	DPC
02356813	JAMP-METOPROLOL-L	JMP
02296713	METOPROLOL	PDL
02442116	METOPROLOL-L	SIV
02248855	PMS-METOPROLOL-L	PMS
02315300	RIVA-METOPROLOL L	RIV
02261898	TEVA-METOPROLOL	TEV

50MG TABLET

00618632	APO METOPROLOL	APX
00749354	APO METOPROLOL (TYPE L)	APX
02172550	DOM-METOPROLOL-B	DPC
02231121	DOM-METOPROLOL-L	DPC
02356821	JAMP-METOPROLOL-L	JMP
00397423	LOPRESOR	NVR
00648019	METOPROLOL	PDL
02350394	METOPROLOL	SAN
02442124	METOPROLOL-L	SIV
02145413	PMS-METOPROLOL-B	PMS
02230803	PMS-METOPROLOL-L	PMS
02315319	RIVA-METOPROLOL L	RIV
02354187	SANDOZ METOPROLOL (TYPE L)	SDZ
00648035	TEVA-METOPROLOL	TEV
00842648	TEVA-METOPROLOL	TEV

100MG TABLET

00618640	APO METOPROLOL	APX
00751170	APO-METOPROLOL (TYPE L)	APX
02172569	DOM-METOPROLOL-B	DPC
02231122	DOM-METOPROLOL-L	DPC
02356848	JAMP-METOPROLOL-L	JMP
00397431	LOPRESOR	NVR
00648027	METOPROLOL	PDL
02350408	METOPROLOL	SAN
02442132	METOPROLOL-L	SIV
02145421	PMS-METOPROLOL-B	PMS
02230804	PMS-METOPROLOL-L	PMS
02315327	RIVA-METOPROLOL L	RIV
02354195	SANDOZ METOPROLOL (TYPE L)	SDZ
00648043	TEVA-METOPROLOL	TEV
00842656	TEVA-METOPROLOL	TEV

100MG TABLET (EXTENDED RELEASE)

02285169	APO-METOPROLOL SR	APX
00658855	LOPRESOR SR	NVR
02351404	METOPROLOL SR	PDL
02303396	SANDOZ METOPROLOL SR	SDZ

200MG TABLET (EXTENDED RELEASE)

02285177	APO-METOPROLOL SR	APX
00534560	LOPRESOR SR	NVR
02351412	METOPROLOL SR	PDL
02303418	SANDOZ METOPROLOL SR	SDZ

PDIN FOR EXTEMPORANEOUS MIXTURE

99503015	METOPROLOL ORAL LIQUID	UNK

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

NADOLOL

40MG TABLET

00782505	NADOLOL	AAP

80MG TABLET

00782467	NADOLOL	AAP

160MG TABLET

00782475	NADOLOL	AAP

PINDOLOL

5MG TABLET

00755877	APO-PINDOL	APX
02231650	DOM-PINDOLOL	DPC
00828416	PINDOLOL	PDL
00869007	TEVA-PINDOLOL	TEV
00417270	VISKEN	TPC

10MG TABLET

00755885	APO-PINDOL	APX
02238046	DOM-PINDOLOL	DPC
00828424	PINDOLOL	PDL
00869015	TEVA-PINDOLOL	TEV
00443174	VISKEN	TPC

15MG TABLET

00755893	APO-PINDOL	APX
02238047	DOM-PINDOLOL	DPC
02231539	PMS-PINDOLOL	PMS
00869023	TEVA-PINDOLOL	TEV

PROPRANOLOL HYDROCHLORIDE

60MG CAPSULE (SUSTAINED RELEASE)

02042231	INDERAL LA	PFI

80MG CAPSULE (SUSTAINED RELEASE)

02042258	INDERAL LA	PFI

120MG CAPSULE (SUSTAINED RELEASE)

02042266	INDERAL LA	PFI

160MG CAPSULE (SUSTAINED RELEASE)

02042274	INDERAL LA	PFI

10MG TABLET

00496480	TEVA-PROPRANOLOL	TEV

20MG TABLET

00740675	TEVA-PROPRANOLOL	TEV

40MG TABLET

00496499	TEVA-PROPRANOLOL	TEV

80MG TABLET

00582271	PMS-PROPRANOLOL	PMS
00496502	TEVA-PROPRANOLOL	TEV

120MG TABLET

00504335	APO PROPRANOLOL	APX
00582298	PMS-PROPRANOLOL	PMS

PDIN FOR EXTEMPORANEOUS MIXTURE

99503014	PROPRANOLOL ORAL LIQUID	UNK

SOTALOL HYDROCHLORIDE

80MG TABLET

02210428	APO-SOTALOL	APX
02270625	CO SOTALOL	OBT
02238634	DOM-SOTALOL	DPC

24:24.00 BETA ADRENERGIC BLOCKING AGENTS

SOTALOL HYDROCHLORIDE

80MG TABLET

02368617	JAMP-SOTALOL	JMP
02238326	PMS-SOTALOL	PMS
02316528	PRO-SOTALOL	PDL
02084228	RATIO-SOTALOL	TEV
02385988	SOTALOL	SIV

160MG TABLET

02167794	APO-SOTALOL	APX
02270633	CO SOTALOL	OBT
02238635	DOM-SOTALOL	DPC
02368625	JAMP-SOTALOL	JMP
02238327	PMS-SOTALOL	PMS
02316536	PRO-SOTALOL	PDL
02084236	RATIO-SOTALOL	TEV
02385996	SOTALOL	SIV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503023	SOTALOL ORAL LIQUID	UNK

TIMOLOL MALEATE

5MG TABLET

00755842	APO-TIMOL	APX

10MG TABLET

00755850	APO-TIMOL	APX

20MG TABLET

00755869	APO-TIMOL	APX

24:28.08 DIHYDROPYRIDINES

AMLODIPINE BESYLATE

2.5MG TABLET

02297477	ACT AMLODIPINE	ACG
02326795	AMLODIPINE	PDL
02385783	AMLODIPINE	SIV
02392127	BIO-AMLODIPINE	BMI
02326825	DOM-AMLODIPINE	DPC
02280124	GD-AMLODIPINE	PFI
02357186	JAMP-AMLODIPINE	JMP
02371707	MAR-AMLODIPINE	MAR
02295148	PMS-AMLODIPINE	PMS
02398877	RAN-AMLODIPINE	RBY
02331489	RIVA-AMLODIPINE	RIV
02330474	SANDOZ AMLODIPINE	SDZ
02357704	SEPTA-AMLODIPINE	SPT

5MG TABLET

02297485	ACT AMLODIPINE	ACG
02326809	AMLODIPINE	PDL
02331284	AMLODIPINE	SAN
02385791	AMLODIPINE	SIV
02429217	AMLODIPINE	JMP
02273373	APO-AMLODIPINE	APX
02397072	AURO-AMLODIPINE	AUR
02392135	BIO-AMLODIPINE	BMI
02326833	DOM-AMLODIPINE	DPC
02280132	GD-AMLODIPINE	PFI
02357194	JAMP-AMLODIPINE	JMP

24:28.08 DIHYDROPYRIDINES

AMLODIPINE BESYLATE

5MG TABLET

02371715	MAR-AMLODIPINE	MAR
02362651	MINT-AMLODIPINE	MIN
02272113	MYLAN-AMLODIPINE	MYL
00878928	NORVASC	PFI
02284065	PMS-AMLODIPINE	PMS
02321858	RAN-AMLODIPINE	RBY
02331497	RIVA-AMLODIPINE	RIV
02284383	SANDOZ AMLODIPINE	SDZ
02357712	SEPTA-AMLODIPINE	SPT
02250497	TEVA-AMLODIPINE	TEV
02426986	VAN-AMLODIPINE	VAN

10MG TABLET

02297493	ACT AMLODIPINE	ACG
02326817	AMLODIPINE	PDL
02331292	AMLODIPINE	SAN
02385805	AMLODIPINE	SIV
02429225	AMLODIPINE	JMP
02273381	APO-AMLODIPINE	APX
02397080	AURO-AMLODIPINE	AUR
02392143	BIO-AMLODIPINE	BMI
02326841	DOM-AMLODIPINE	DPC
02280140	GD-AMLODIPINE	PFI
02357208	JAMP-AMLODIPINE	JMP
02371723	MAR-AMLODIPINE	MAR
02362678	MINT-AMLODIPINE	MIN
02272121	MYLAN-AMLODIPINE	MYL
00878936	NORVASC	PFI
02284073	PMS-AMLODIPINE	PMS
02321866	RAN-AMLODIPINE	RBY
02331500	RIVA-AMLODIPINE	RIV
02284391	SANDOZ AMLODIPINE	SDZ
02357720	SEPTA-AMLODIPINE	SPT
02250500	TEVA-AMLODIPINE	TEV
02426994	VAN-AMLODIPINE	VAN

PDIN FOR EXTEMPORANEOUS MIXTURE

99503003	AMLODIPINE ORAL LIQUID	UNK

AMLODIPINE BESYLATE, ATORVASTATIN CALCIUM

5MG & 10MG TABLET

02411253	APO-AMLODIPINE-ATORVASTATIN	APX
02273233	CADUET	PFI
02362759	GD-AMLODIPINE-ATORVASTATIN	PFI
02404222	PMS-AMLODIPINE-ATORVASTATIN	PMS

5MG & 20MG TABLET

02411261	APO-AMLODIPINE-ATORVASTATIN	APX
02273241	CADUET	PFI
02362767	GD-AMLODIPINE-ATORVASTATIN	PFI
02404230	PMS-AMLODIPINE-ATORVASTATIN	PMS

5MG & 40MG TABLET

02411288	APO-AMLODIPINE-ATORVASTATIN	APX
02273268	CADUET	PFI
02362775	GD-AMLODIPINE-ATORVASTATIN	PFI

24:28.08 DIHYDROPYRIDINES

AMLODIPINE BESYLATE, ATORVASTATIN CALCIUM

5MG & 80MG TABLET

02411296	APO-AMLODIPINE-ATORVASTATIN	APX
02273276	CADUET	PFI
02362783	GD-AMLODIPINE-ATORVASTATIN	PFI

10MG & 10MG TABLET

02411318	APO-AMLODIPINE-ATORVASTATIN	APX
02273284	CADUET	PFI
02362791	GD-AMLODIPINE-ATORVASTATIN	PFI
02404249	PMS-AMLODIPINE-ATORVASTATIN	PMS

10MG & 20MG TABLET

02411326	APO-AMLODIPINE-ATORVASTATIN	APX
02273292	CADUET	PFI
02362805	GD-AMLODIPINE-ATORVASTATIN	PFI
02404257	PMS-AMLODIPINE-ATORVASTATIN	PMS

10MG & 40MG TABLET

02411334	APO-AMLODIPINE-ATORVASTATIN	APX
02273306	CADUET	PFI
02362813	GD-AMLODIPINE-ATORVASTATIN	PFI

10MG & 80MG TABLET

02411342	APO-AMLODIPINE-ATORVASTATIN	APX
02273314	CADUET	PFI
02362821	GD-AMLODIPINE-ATORVASTATIN	PFI

AMLODIPINE BESYLATE, TELMISARTAN

5MG & 40MG TABLET

02371022	TWYNSTA	BOE

5MG & 80MG TABLET

02371049	TWYNSTA	BOE

10MG & 40MG TABLET

02371030	TWYNSTA	BOE

10MG & 80MG TABLET

02371057	TWYNSTA	BOE

FELODIPINE

2.5MG TABLET (EXTENDED RELEASE)

02452367	APO-FELODIPINE	APX
02057778	PLENDIL	AZC

5MG TABLET (EXTENDED RELEASE)

02452375	APO-FELODIPINE	APX
00851779	PLENDIL	AZC
02280264	SANDOZ FELODIPINE	SDZ
09857203	SANDOZ-FELODIPINE	SDZ

10MG TABLET (EXTENDED RELEASE)

02452383	APO-FELODIPINE	APX
00851787	PLENDIL	AZC
02280272	SANDOZ FELODIPINE	SDZ
09857204	SANDOZ-FELODIPINE	SDZ

NIFEDIPINE

5MG CAPSULE

00725110	NIFEDIPINE	AAP
02235897	PMS-NIFEDIPINE	PMS

10MG CAPSULE

00755907	NIFEDIPINE	AAP
02235898	PMS-NIFEDIPINE	PMS

24:28.08 DIHYDROPYRIDINES

NIFEDIPINE

ST **10MG TABLET (EXTENDED RELEASE)**

02197448	APO-NIFED PA	APX

ST **20MG TABLET (EXTENDED RELEASE)**

02237618	ADALAT XL	BAY
02181525	APO-NIFED PA	APX

ST **30MG TABLET (EXTENDED RELEASE)**

02155907	ADALAT XL	BAY
02349167	MYLAN-NIFEDIPINE	MYL
02421631	NIFEDIPINE	PDL
02442930	NIFEDIPINE	SIV
02418630	PMS-NIFEDIPINE	PMS

ST **60MG TABLET (EXTENDED RELEASE)**

02155990	ADALAT XL	BAY
02321149	MYLAN-NIFEDIPINE	MYL
02421658	NIFEDIPINE	PDL
02442949	NIFEDIPINE	SIV
02416301	PMS-NIFEDIPINE	PMS

NIMODIPINE

ST **30MG TABLET**

02325926	NIMOTOP	BAY

24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS

DILTIAZEM HYDROCHLORIDE

ST **120MG CAPSULE (CONTROLLED DELIVERY)**

02230997	APO-DILTIAZ CD	APX
02231472	DILTIAZEM CD	PDL
02400421	DILTIAZEM CD	SAN
02355752	PMS-DILTIAZEM CD	PMS

ST **180MG CAPSULE (CONTROLLED DELIVERY)**

02230998	APO-DILTIAZ CD	APX
02231474	DILTIAZEM CD	PDL
02400448	DILTIAZEM CD	SAN
02355760	PMS-DILTIAZEM CD	PMS

ST **240MG CAPSULE (CONTROLLED DELIVERY)**

02230999	APO-DILTIAZ CD	APX
02231475	DILTIAZEM CD	PDL
02400456	DILTIAZEM CD	SAN
02355779	PMS-DILTIAZEM CD	PMS

ST **300MG CAPSULE (CONTROLLED DELIVERY)**

02229526	APO-DILTIAZ CD	APX
02231057	DILTIAZEM CD	PDL
02400464	DILTIAZEM CD	SAN
02355787	PMS-DILTIAZEM CD	PMS

ST **120MG CAPSULE (EXTENDED RELEASE)**

02370611	ACT DILTIAZEM CD	TEV
02370441	ACT DILTIAZEM T	ACG
02097249	CARDIZEM CD	VAE
02445999	DILTIAZEM CD	SIV
02325306	DILTIAZEM TZ	PDL
02243338	SANDOZ DILTIAZEM CD	SDZ
02245918	SANDOZ DILTIAZEM T	SDZ
02271605	TEVA-DILTIAZEM	VAE
02242538	TEVA-DILTIAZEM CD	TEV

24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS

DILTIAZEM HYDROCHLORIDE

ST **120MG CAPSULE (EXTENDED RELEASE)**

02231150	TIAZAC	VAE

ST **180MG CAPSULE (EXTENDED RELEASE)**

02370638	ACT DILTIAZEM CD	TEV
02370492	ACT DILTIAZEM T	ACG
02097257	CARDIZEM CD	VAE
02446006	DILTIAZEM CD	SIV
02325314	DILTIAZEM TZ	PDL
02243339	SANDOZ DILTIAZEM CD	SDZ
02245919	SANDOZ DILTIAZEM T	SDZ
02271613	TEVA-DILTIAZEM	VAE
02242539	TEVA-DILTIAZEM CD	TEV
02231151	TIAZAC	VAE

ST **240MG CAPSULE (EXTENDED RELEASE)**

02370646	ACT DILTIAZEM CD	TEV
02370506	ACT DILTIAZEM T	ACG
02097265	CARDIZEM CD	VAE
02446014	DILTIAZEM CD	SIV
02325322	DILTIAZEM TZ	PDL
02243340	SANDOZ DILTIAZEM CD	SDZ
02245920	SANDOZ DILTIAZEM T	SDZ
02271621	TEVA-DILTIAZEM	VAE
02242540	TEVA-DILTIAZEM CD	TEV
02231152	TIAZAC	VAE

ST **300MG CAPSULE (EXTENDED RELEASE)**

02370654	ACT DILTIAZEM CD	TEV
02370514	ACT DILTIAZEM T	ACG
02097273	CARDIZEM CD	VAE
02446022	DILTIAZEM CD	SIV
02325330	DILTIAZEM TZ	PDL
02243341	SANDOZ DILTIAZEM CD	SDZ
02245921	SANDOZ DILTIAZEM T	SDZ
02271648	TEVA-DILTIAZEM	VAE
02242541	TEVA-DILTIAZEM CD	TEV
02231154	TIAZAC	VAE

ST **360MG CAPSULE (EXTENDED RELEASE)**

02370522	ACT DILTIAZEM T	ACG
02325349	DILTIAZEM TZ	PDL
02245922	SANDOZ DILTIAZEM T	SDZ
02271656	TEVA-DILTIAZEM	VAE
02231155	TIAZAC	VAE

ST **60MG CAPSULE (SUSTAINED RELEASE)**

02222957	APO-DILTIAZ SR	APX

ST **90MG CAPSULE (SUSTAINED RELEASE)**

02222965	APO-DILTIAZ SR	APX

ST **120MG CAPSULE (SUSTAINED RELEASE)**

02222973	APO-DILTIAZ SR	APX

ST **30MG TABLET**

00771376	APO DILTIAZ	APX
00862924	TEVA-DILTIAZEM	TEV

ST **60MG TABLET**

00771384	APO DILTIAZ	APX
00862932	TEVA-DILTIAZEM	TEV

24:28.92 MISCELLANEOUS CALCIUM-CHANNEL BLOCKING AGENTS

DILTIAZEM HYDROCHLORIDE

ST **120MG TABLET (EXTENDED RELEASE)**

02256738	TIAZAC XC	VAE

ST **180MG TABLET (EXTENDED RELEASE)**

02256746	TIAZAC XC	VAE

ST **240MG TABLET (EXTENDED RELEASE)**

02256754	TIAZAC XC	VAE

ST **300MG TABLET (EXTENDED RELEASE)**

02256762	TIAZAC XC	VAE

ST **360MG TABLET (EXTENDED RELEASE)**

02256770	TIAZAC XC	VAE

VERAPAMIL HYDROCHLORIDE

120MG CAPSULE (SUSTAINED RELEASE)

02100479	VERELAN	RGL

ST **180MG CAPSULE (SUSTAINED RELEASE)**

02100487	VERELAN	RGL

ST **240MG CAPSULE (SUSTAINED RELEASE)**

02100495	VERELAN	RGL

ST **80MG TABLET**

00782483	APO-VERAP	APX
02237921	MYLAN-VERAPAMIL	MYL
00812331	NOVO-VERAMIL	TEV

ST **120MG TABLET**

00782491	APO-VERAP	APX
02237922	MYLAN-VERAPAMIL	MYL
00812358	NOVO-VERAMIL	TEV

ST **120MG TABLET (EXTENDED RELEASE)**

02246893	APO-VERAP SR	APX
01907123	ISOPTIN SR	BGP
02210347	MYLAN-VERAPAMIL SR	MYL

ST **180MG TABLET (EXTENDED RELEASE)**

02246894	APO-VERAP SR	APX
01934317	ISOPTIN SR	BGP
02450488	MYLAN-VERAPAMIL	MYL

ST **240MG TABLET (EXTENDED RELEASE)**

02246895	APO-VERAP SR	APX
02240321	DOM-VERAPAMIL SR	DPC
00742554	ISOPTIN SR	BGP
02450496	MYLAN-VERAPAMIL	MYL
02211920	NOVO-VERAMIL SR	TEV
02237791	PMS-VERAPAMIL SR	PMS
02312697	PRO-VERAPAMIL SR	PDL
02248082	RIVA-VERAPAMIL SR	RIV

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

BENAZEPRIL HYDROCHLORIDE

ST **5MG TABLET**

02290332	BENAZEPRIL	AAP

ST **10MG TABLET**

02290340	BENAZEPRIL	AAP

ST **20MG TABLET**

02273918	BENAZEPRIL	AAP
00885851	LOTENSIN	NVR

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

CAPTOPRIL

ST **6.25MG TABLET**

01999559	APO-CAPTO	APX

ST **12.5MG TABLET**

00893595	APO-CAPTO	APX
01942964	TEVA-CAPTOPRIL	TEV

ST **25MG TABLET**

00893609	APO-CAPTO	APX
01942972	TEVA-CAPTOPRIL	TEV

ST **50MG TABLET**

00893617	APO-CAPTO	APX
01942980	TEVA-CAPTOPRIL	TEV

ST **100MG TABLET**

00893625	APO-CAPTO	APX
02230206	PMS-CAPTOPRIL	PMS
01942999	TEVA-CAPTOPRIL	TEV

CILAZAPRIL

ST **1MG TABLET**

02291134	APO-CILAZAPRIL	APX
02283778	MYLAN-CILAZAPRIL	MYL
02280442	PMS-CILAZAPRIL	PMS
02266350	TEVA-CILAZAPRIL	TEV

ST **2.5MG TABLET**

02291142	APO-CILAZAPRIL	APX
02285215	CO CILAZAPRIL	OBT
01911473	INHIBACE	HLR
02283786	MYLAN-CILAZAPRIL	MYL
02280450	PMS-CILAZAPRIL	PMS
02266369	TEVA-CILAZAPRIL	TEV

ST **5MG TABLET**

02291150	APO-CILAZAPRIL	APX
02285223	CO CILAZAPRIL	OBT
01911481	INHIBACE	HLR
02283794	MYLAN-CILAZAPRIL	MYL
02280469	PMS-CILAZAPRIL	PMS
02266377	TEVA-CILAZAPRIL	TEV

CILAZAPRIL, HYDROCHLOROTHIAZIDE

ST **5MG & 12.5MG TABLET**

02284987	APO-CILAZAPRIL/HCTZ	APX
02181479	INHIBACE PLUS	HLR
02313731	NOVO-CILAZAPRIL/HCTZ	TEV

ENALAPRIL MALEATE

ST **2.5MG TABLET**

02291878	ACT ENALAPRIL	TEV
02020025	APO-ENALAPRIL	APX
02400650	ENALAPRIL	SAN
02442957	ENALAPRIL	SIV
02300036	MYLAN-ENALAPRIL	MYL
02311402	PRO-ENALAPRIL	PDL
02352230	RAN-ENALAPRIL	RBY
02300796	RIVA-ENALAPRIL	RIV
02299933	SANDOZ ENALAPRIL	SDZ
02300117	TARO-ENALAPRIL	TAR

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

ENALAPRIL MALEATE

2.5MG TABLET

02300680	TEVA-ENALAPRIL	TEV

5MG TABLET

02291886	ACT ENALAPRIL	TEV
02019884	APO-ENALAPRIL	APX
02400669	ENALAPRIL	SAN
02442965	ENALAPRIL	SIV
02300044	MYLAN-ENALAPRIL	MYL
02311410	PRO-ENALAPRIL	PDL
02352249	RAN-ENALAPRIL	RBY
02300818	RIVA-ENALAPRIL	RIV
02299941	SANDOZ ENALAPRIL	SDZ
02300125	TARO-ENALAPRIL	TAR
02233005	TEVA-ENALAPRIL	TEV
00708879	VASOTEC	FRS

10MG TABLET

02291894	ACT ENALAPRIL	TEV
02019892	APO-ENALAPRIL	APX
02400677	ENALAPRIL	SAN
02442973	ENALAPRIL	SIV
02300052	MYLAN-ENALAPRIL	MYL
02311429	PRO-ENALAPRIL	PDL
02352257	RAN-ENALAPRIL	RBY
02300826	RIVA-ENALAPRIL	RIV
02299968	SANDOZ ENALAPRIL	SDZ
02300133	TARO-ENALAPRIL	TAR
02233006	TEVA-ENALAPRIL	TEV
00670901	VASOTEC	FRS

20MG TABLET

02291908	ACT ENALAPRIL	TEV
02019906	APO-ENALAPRIL	APX
02400685	ENALAPRIL	SAN
02442981	ENALAPRIL	SIV
02300060	MYLAN-ENALAPRIL	MYL
02311437	PRO-ENALAPRIL	PDL
02352265	RAN-ENALAPRIL	RBY
02300834	RIVA-ENALAPRIL	RIV
02299976	SANDOZ ENALAPRIL	SDZ
02300141	TARO-ENALAPRIL	TAR
02233007	TEVA-ENALAPRIL	TEV
00670928	VASOTEC	FRS

PDIN FOR EXTEMPORANEOUS MIXTURE

99503013	ENALAPRIL ORAL LIQUID	UNK

ENALAPRIL MALEATE, HYDROCHLOROTHIAZIDE

5MG & 12.5MG TABLET

02352923	ENALAPRIL MALEATE/HCTZ	APX

10MG & 25MG TABLET

02352931	ENALAPRIL MALEATE/HCTZ	APX
00657298	VASERETIC	FRS

FOSINOPRIL SODIUM

10MG TABLET

02266008	APO-FOSINOPRIL	APX

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

FOSINOPRIL SODIUM

10MG TABLET

02303000	FOSINOPRIL	PDL
02332566	FOSINOPRIL	RBY
02459388	FOSINOPRIL	SAN
02331004	JAMP-FOSINOPRIL	JMP
02255944	PMS-FOSINOPRIL	PMS
02294524	RAN-FOSINOPRIL	RBY
02247802	TEVA-FOSINOPRIL	TEV

20MG TABLET

02266016	APO-FOSINOPRIL	APX
02303019	FOSINOPRIL	PDL
02332574	FOSINOPRIL	RBY
02459396	FOSINOPRIL	SAN
02331012	JAMP-FOSINOPRIL	JMP
02255952	PMS-FOSINOPRIL	PMS
02294532	RAN-FOSINOPRIL	RBY
02247803	TEVA-FOSINOPRIL	TEV

LISINOPRIL

5MG TABLET

02271443	ACT LISINOPRIL	ACG
02217481	APO-LISINOPRIL	APX
09853685	APO-LISINOPRIL	APX
02394472	AURO-LISINOPRIL	AUR
02361531	JAMP-LISINOPRIL	JMP
02386232	LISINOPRIL	SIV
02292203	PMS-LISINOPRIL	PMS
02310961	PRO-LISINOPRIL	PDL
02294230	RAN-LISINOPRIL	RBY
02300958	RIVA-LISINOPRIL	RIV
02289199	SANDOZ LISINOPRIL	SDZ
02285061	TEVA-LISINOPRIL (TYPE P)	TEV
02285118	TEVA-LISINOPRIL (TYPE Z)	TEV
02049333	ZESTRIL	AZC

10MG TABLET

02271451	ACT LISINOPRIL	ACG
02217503	APO-LISINOPRIL	APX
09853960	APO-LISINOPRIL	APX
02394480	AURO-LISINOPRIL	AUR
02361558	JAMP-LISINOPRIL	JMP
02386240	LISINOPRIL	SIV
02292211	PMS-LISINOPRIL	PMS
00839396	PRINIVIL	FRS
02310988	PRO-LISINOPRIL	PDL
02294249	RAN-LISINOPRIL	RBY
02300982	RIVA-LISINOPRIL	RIV
02289202	SANDOZ LISINOPRIL	SDZ
02285088	TEVA-LISINOPRIL (TYPE P)	TEV
02285126	TEVA-LISINOPRIL (TYPE Z)	TEV
02049376	ZESTRIL	AZC

20MG TABLET

02271478	ACT LISINOPRIL	ACG
02217511	APO-LISINOPRIL	APX
09854010	APO-LISINOPRIL	APX

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

LISINOPRIL

ST **20MG TABLET**

02394499	AURO-LISINOPRIL	AUR
02361566	JAMP-LISINOPRIL	JMP
02386259	LISINOPRIL	SIV
02274868	MYLAN-LISINOPRIL	MYL
02292238	PMS-LISINOPRIL	PMS
00839418	PRINIVIL	FRS
02310996	PRO-LISINOPRIL	PDL
02294257	RAN-LISINOPRIL	RBY
02300990	RIVA-LISINOPRIL	RIV
02289229	SANDOZ LISINOPRIL	SDZ
02285096	TEVA-LISINOPRIL (TYPE P)	TEV
02285134	TEVA-LISINOPRIL (TYPE Z)	TEV
02049384	ZESTRIL	AZC

LISINOPRIL, HYDROCHLOROTHIAZIDE

ST **10MG & 12.5MG TABLET**

02362945	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302365	SANDOZ LISINOPRIL HCT	SDZ
02302136	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301768	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02103729	ZESTORETIC	AZC

ST **20MG & 12.5MG TABLET**

02362953	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302373	SANDOZ LISINOPRIL HCT	SDZ
02302144	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301776	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02045737	ZESTORETIC	AZC

ST **20MG & 25MG TABLET**

02362961	LISINOPRIL/HCTZ (TYPE Z)	SAN
02302381	SANDOZ LISINOPRIL HCT	SDZ
02302152	TEVA-LISINOPRIL/HCTZ (TYPE P)	TEV
02301784	TEVA-LISINOPRIL/HCTZ (TYPE Z)	TEV
02045729	ZESTORETIC	AZC

PERINDOPRIL ERBUMINE

ST **2MG TABLET**

02123274	COVERSYL	SEV

ST **4MG TABLET**

02123282	COVERSYL	SEV

ST **8MG TABLET**

02246624	COVERSYL	SEV

PERINDOPRIL ERBUMINE, INDAPAMIDE

ST **4MG & 1.25MG TABLET**

02246569	COVERSYL PLUS	SEV

ST **8MG & 2.5MG TABLET**

02321653	COVERSYL PLUS HD	SEV

QUINAPRIL

ST **5MG TABLET**

01947664	ACCUPRIL	PFI
02248499	APO-QUINAPRIL	APX
02290987	GD-QUINAPRIL	PFI
02340550	PMS-QUINAPRIL	PMS
02415917	QUINAPRIL	PDL

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

QUINAPRIL

ST **10MG TABLET**

01947672	ACCUPRIL	PFI
02248500	APO-QUINAPRIL	APX
02290995	GD-QUINAPRIL	PFI
02340569	PMS-QUINAPRIL	PMS
02415925	QUINAPRIL	PDL

ST **20MG TABLET**

01947680	ACCUPRIL	PFI
02248501	APO-QUINAPRIL	APX
02291002	GD-QUINAPRIL	PFI
02340577	PMS-QUINAPRIL	PMS
02415933	QUINAPRIL	PDL

ST **40MG TABLET**

01947699	ACCUPRIL	PFI
02248502	APO-QUINAPRIL	APX
02291010	GD-QUINAPRIL	PFI
02340585	PMS-QUINAPRIL	PMS
02415941	QUINAPRIL	PDL

QUINAPRIL, HYDROCHLOROTHIAZIDE

ST **10MG & 12.5MG TABLET**

02237367	ACCURETIC	PFI
02408767	APO-QUINAPRIL/HCTZ	APX

ST **20MG & 12.5MG TABLET**

02237368	ACCURETIC	PFI
02408775	APO-QUINAPRIL/HCTZ	APX

ST **20MG & 25MG TABLET**

02237369	ACCURETIC	PFI
02408783	APO-QUINAPRIL/HCTZ	APX

RAMIPRIL

ST **1.25MG CAPSULE**

02295482	ACT RAMIPRIL	ACG
02221829	ALTACE	VAE
02251515	APO-RAMIPRIL	APX
02387387	AURO-RAMIPRIL	AUR
02331101	JAMP-RAMIPRIL	JMP
02420457	MAR-RAMIPRIL	MAR
02295369	PMS-RAMIPRIL	PMS
02310023	PRO-RAMIPRIL	PDL
02299372	RAMIPRIL	RIV
02308363	RAMIPRIL	SIV
02310503	RAN-RAMIPRIL	RBY
02438860	VAN-RAMIPRIL	VAN

ST **2.5MG CAPSULE**

02295490	ACT RAMIPRIL	ACG
02221837	ALTACE	VAE
02251531	APO-RAMIPRIL	APX
02387395	AURO-RAMIPRIL	AUR
02287951	DOM-RAMIPRIL	DPC
02331128	JAMP-RAMIPRIL	JMP
02420465	MAR-RAMIPRIL	MAR
02421305	MINT-RAMIPRIL	MIN
02247917	PMS-RAMIPRIL	PMS
02310066	PRO-RAMIPRIL	PDL

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

RAMIPRIL

ST **2.5MG CAPSULE**

02255316	RAMIPRIL	RIV
02287927	RAMIPRIL	SIV
02374846	RAMIPRIL	SAN
02411563	RAMIPRIL-2.5	SIV
02310511	RAN-RAMIPRIL	RBY
02247945	TEVA-RAMIPRIL	TEV
02438879	VAN-RAMIPRIL	VAN

ST **5MG CAPSULE**

02295504	ACT RAMIPRIL	ACG
02221845	ALTACE	VAE
02251574	APO-RAMIPRIL	APX
02387409	AURO-RAMIPRIL	AUR
02287978	DOM-RAMIPRIL	DPC
02331136	JAMP-RAMIPRIL	JMP
02420473	MAR-RAMIPRIL	MAR
02421313	MINT-RAMIPRIL	MIN
02247918	PMS-RAMIPRIL	PMS
02310074	PRO-RAMIPRIL	PDL
02255324	RAMIPRIL	RIV
02287935	RAMIPRIL	SIV
02374854	RAMIPRIL	SAN
02411571	RAMIPRIL-5	SIV
02310538	RAN-RAMIPRIL	RBY
02247946	TEVA-RAMIPRIL	TEV
02438887	VAN-RAMIPRIL	VAN

ST **10MG CAPSULE**

02295512	ACT RAMIPRIL	ACG
02221853	ALTACE	VAE
02251582	APO-RAMIPRIL	APX
02387417	AURO-RAMIPRIL	AUR
02287986	DOM-RAMIPRIL	DPC
02331144	JAMP-RAMIPRIL	JMP
02420481	MAR-RAMIPRIL	MAR
02421321	MINT-RAMIPRIL	MIN
02247919	PMS-RAMIPRIL	PMS
02310104	PRO-RAMIPRIL	PDL
02255332	RAMIPRIL	RIV
02287943	RAMIPRIL	SIV
02374862	RAMIPRIL	SAN
02411598	RAMIPRIL-10	SIV
02310546	RAN-RAMIPRIL	RBY
02247947	TEVA-RAMIPRIL	TEV
02438895	VAN-RAMIPRIL	VAN

ST **15MG CAPSULE**

02325381	APO-RAMIPRIL	APX
02440334	JAMP-RAMIPRIL	JMP
02420503	MAR-RAMIPRIL	MAR
02421348	MINT-RAMIPRIL	MIN
02343932	PMS-RAMIPRIL	PMS
02425548	RAN-RAMIPRIL	RBY
02438909	VAN-RAMIPRIL	VAN

ST **1.25MG TABLET**

02291398	SANDOZ RAMIPRIL	SDZ

24:32.04 ANGIOTENSIN-CONVERTING ENZYME INHIBITORS

RAMIPRIL

ST **2.5MG TABLET**

02291401	SANDOZ RAMIPRIL	SDZ

ST **5MG TABLET**

02291428	SANDOZ RAMIPRIL	SDZ

ST **10MG TABLET**

02291436	SANDOZ RAMIPRIL	SDZ

RAMIPRIL, HYDROCHLOROTHIAZIDE

ST **2.5MG & 12.5MG TABLET**

02283131	ALTACE HCT	VAE
02354004	APO-RAMIPRIL/HCTZ	APX
02342138	PMS-RAMIPRIL-HCTZ	PMS

ST **5MG & 12.5MG TABLET**

02283158	ALTACE HCT	VAE
02354012	APO-RAMIPRIL/HCTZ	APX
02342146	PMS-RAMIPRIL-HCTZ	PMS
02415887	RAMIPRIL-HCTZ	PDL

ST **5MG & 25MG TABLET**

02283174	ALTACE HCT	VAE
02354020	APO-RAMIPRIL/HCTZ	APX
02342162	PMS-RAMIPRIL-HCTZ	PMS

ST **10MG & 12.5MG TABLET**

02283166	ALTACE HCT	VAE
02342154	PMS-RAMIPRIL-HCTZ	PMS
02415895	RAMIPRIL-HCTZ	PDL

ST **10MG & 25MG TABLET**

02283182	ALTACE HCT	VAE
02354039	APO-RAMIPRIL/HCTZ	APX
02342170	PMS-RAMIPRIL-HCTZ	PMS
02415909	RAMIPRIL-HCTZ	PDL

TRANDOLAPRIL

ST **0.5MG CAPSULE**

02231457	MAVIK	BGP

ST **1MG CAPSULE**

02231459	MAVIK	BGP

ST **2MG CAPSULE**

02231460	MAVIK	BGP

ST **4MG CAPSULE**

02239267	MAVIK	BGP

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

AZILSARTAN MEDOXOMIL

ST **40MG TABLET**

02381389	EDARBI	VAE

ST **80MG TABLET**

02381397	EDARBI	VAE

CANDESARTAN CILEXETIL

ST **4MG TABLET**

02379260	ACH-CANDESARTAN	ACC
02376520	ACT CANDESARTAN	ACG
02365340	APO-CANDESARTAN	APX
02239090	ATACAND	AZC

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

CANDESARTAN CILEXETIL

ST **4MG TABLET**

02388901	CANDESARTAN	SAN
02386496	JAMP-CANDESARTAN	JMP
02379120	MYLAN-CANDESARTAN	MYL
02391171	PMS-CANDESARTAN	PMS
02380684	RAN-CANDESARTAN	RBY
02425408	RIVA-CANDESARTAN	RIV
02326957	SANDOZ CANDESARTAN	SDZ

ST **8MG TABLET**

02379279	ACH-CANDESARTAN	ACC
02376539	ACT CANDESARTAN	ACG
02365359	APO-CANDESARTAN	APX
02239091	ATACAND	AZC
02377934	CANDESARTAN	PDL
02388707	CANDESARTAN	SIV
02388928	CANDESARTAN	SAN
02395762	DOM-CANDESARTAN	DPC
02386518	JAMP-CANDESARTAN	JMP
02379139	MYLAN-CANDESARTAN	MYL
02391198	PMS-CANDESARTAN	PMS
02380692	RAN-CANDESARTAN	RBY
02425416	RIVA-CANDESARTAN	RIV
02326965	SANDOZ CANDESARTAN	SDZ
02366312	TEVA-CANDESARTAN	TEV

ST **16MG TABLET**

02379287	ACH-CANDESARTAN	ACC
02376547	ACT CANDESARTAN	ACG
02365367	APO-CANDESARTAN	APX
02239092	ATACAND	AZC
02377942	CANDESARTAN	PDL
02388715	CANDESARTAN	SIV
02388936	CANDESARTAN	SAN
02386526	JAMP-CANDESARTAN	JMP
02379147	MYLAN-CANDESARTAN	MYL
02391201	PMS-CANDESARTAN	PMS
02380706	RAN-CANDESARTAN	RBY
02425424	RIVA-CANDESARTAN	RIV
02326973	SANDOZ CANDESARTAN	SDZ
02366320	TEVA-CANDESARTAN	TEV

ST **32MG TABLET**

02379295	ACH-CANDESARTAN	ACC
02376555	ACT CANDESARTAN	ACG
02399105	APO-CANDESARTAN	APX
02311658	ATACAND	AZC
02422069	CANDESARTAN	PDL
02435845	CANDESARTAN	SAN
02386534	JAMP-CANDESARTAN	JMP
02379155	MYLAN-CANDESARTAN	MYL
02391228	PMS-CANDESARTAN	PMS
02380714	RAN-CANDESARTAN	RBY
02425432	RIVA-CANDESARTAN	RIV
02392267	SANDOZ CANDESARTAN	SDZ
02417340	SANDOZ CANDESARTAN	SDZ
02366339	TEVA-CANDESARTAN	TEV

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

CANDESARTAN CILEXETIL, HYDROCHLOROTHIAZIDE

ST **16MG & 12.5MG TABLET**

02388650	ACT CANDESARTAN/HCT	ACG
02367866	APO-CANDESARTAN/HCTZ	APX
02244021	ATACAND PLUS	AZC
02421038	AURO-CANDESARTAN HCT	AUR
02394812	CANDESARTAN-HCT	SIV
02392275	CANDESARTAN-HCTZ	PDL
02394804	CANDESARTAN-HCTZ	SAN
02391295	PMS-CANDESARTAN HCTZ	PMS
02327902	SANDOZ CANDESARTAN PLUS	SDZ
02395541	TEVA-CANDESARTAN/HCTZ	TEV

ST **32MG & 12.5MG TABLET**

02395126	APO-CANDESARTAN/HCTZ	APX
02332922	ATACAND PLUS	AZC
02421046	AURO-CANDESARTAN HCT	AUR
02420732	SANDOZ CANDESARTAN PLUS	SDZ
02395568	TEVA-CANDESARTAN/HCTZ	TEV

ST **32MG & 25MG TABLET**

02395134	APO-CANDESARTAN/HCTZ	APX
02332957	ATACAND PLUS	AZC
02421054	AURO-CANDESARTAN HCT	AUR
02420740	SANDOZ CANDESARTAN PLUS	SDZ

EPOSARTAN MESYLATE

ST **400MG TABLET**

02240432	TEVETEN	BGP

ST **600MG TABLET**

02243942	TEVETEN	BGP

EPOSARTAN MESYLATE, HYDROCHLOROTHIAZIDE

ST **600MG & 12.5MG TABLET**

02253631	TEVETEN PLUS	BGP

IRBESARTAN

ST **75MG TABLET**

02328070	ACT IRBESARTAN	ACG
02386968	APO-IRBESARTAN	APX
02406098	AURO-IRBESARTAN	AUR
02237923	AVAPRO	SAC
02365197	IRBESARTAN	PDL
02372347	IRBESARTAN	SAN
02385287	IRBESARTAN	SIV
02418193	JAMP-IRBESARTAN	JMP
02422980	MINT-IRBESARTAN	MIN
02347296	MYLAN-IRBESARTAN	MYL
02317060	PMS-IRBESARTAN	PMS
02406810	RAN-IRBESARTAN	RBY
02316390	RATIO-IRBESARTAN	TEV
02425319	RIVA-IRBESARTAN	RIV
02328461	SANDOZ IRBESARTAN	SDZ
02315971	TEVA-IRBESARTAN	TEV
02427087	VAN-IRBESARTAN	VAN

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

IRBESARTAN

ST **150MG TABLET**

02328089	ACT IRBESARTAN	ACG
02386976	APO-IRBESARTAN	APX
02406101	AURO-IRBESARTAN	AUR
02237924	AVAPRO	SAC
02372193	DOM-IRBESARTAN	DPC
02365200	IRBESARTAN	PDL
02372371	IRBESARTAN	SAN
02385295	IRBESARTAN	SIV
02418207	JAMP-IRBESARTAN	JMP
02422999	MINT-IRBESARTAN	MIN
02347318	MYLAN-IRBESARTAN	MYL
02317079	PMS-IRBESARTAN	PMS
02406829	RAN-IRBESARTAN	RBY
02316404	RATIO-IRBESARTAN	TEV
02425327	RIVA-IRBESARTAN	RIV
02328488	SANDOZ IRBESARTAN	SDZ
02315998	TEVA-IRBESARTAN	TEV
02427095	VAN-IRBESARTAN	VAN

ST **300MG TABLET**

02328100	ACT IRBESARTAN	ACG
02386984	APO-IRBESARTAN	APX
02406128	AURO-IRBESARTAN	AUR
02237925	AVAPRO	SAC
02365219	IRBESARTAN	PDL
02372398	IRBESARTAN	SAN
02385309	IRBESARTAN	SIV
02418215	JAMP-IRBESARTAN	JMP
02423006	MINT-IRBESARTAN	MIN
02317087	PMS-IRBESARTAN	PMS
02406837	RAN-IRBESARTAN	RBY
02316412	RATIO-IRBESARTAN	TEV
02425335	RIVA-IRBESARTAN	RIV
02328496	SANDOZ IRBESARTAN	SDZ
02316005	TEVA-IRBESARTAN	TEV
02427109	VAN-IRBESARTAN	VAN

IRBESARTAN, HYDROCHLOROTHIAZIDE

ST **150MG & 12.5MG TABLET**

02357399	ACT IRBESARTAN/HCT	ACG
02387646	APO-IRBESARTAN/HCTZ	APX
02447878	AURO-IRBESARTAN HCT	AUR
02241818	AVALIDE	SAC
02385317	IRBESARTAN HCT	SIV
02372886	IRBESARTAN/HCTZ	SAN
02365162	IRBESARTAN-HCTZ	PDL
02418223	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02392992	MINT-IRBESARTAN/HCTZ	MIN
02328518	PMS-IRBESARTAN-HCTZ	PMS
02363208	RAN-IRBESARTAN HCTZ	RBY
02330512	RATIO-IRBESARTAN HCTZ	TEV
02337428	SANDOZ IRBESARTAN HCT	SDZ
02316013	TEVA-IRBESARTAN/HCTZ	TEV

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

IRBESARTAN, HYDROCHLOROTHIAZIDE

ST **300MG & 12.5MG TABLET**

02357402	ACT IRBESARTAN/HCT	ACG
02387654	APO-IRBESARTAN/HCTZ	APX
02447886	AURO-IRBESARTAN HCT	AUR
02241819	AVALIDE	SAC
02385325	IRBESARTAN HCT	SIV
02372894	IRBESARTAN/HCTZ	SAN
02365170	IRBESARTAN-HCTZ	PDL
02418231	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02393018	MINT-IRBESARTAN/HCTZ	MIN
02328526	PMS-IRBESARTAN-HCTZ	PMS
02363216	RAN-IRBESARTAN HCTZ	RBY
02330520	RATIO-IRBESARTAN HCTZ	TEV
02337436	SANDOZ IRBESARTAN HCT	SDZ
02316021	TEVA-IRBESARTAN/HCTZ	TEV

ST **300MG & 25MG TABLET**

02357410	ACT IRBESARTAN/HCT	ACG
02387662	APO-IRBESARTAN/HCTZ	APX
02447894	AURO-IRBESARTAN HCT	AUR
02385333	IRBESARTAN HCT	SIV
02372908	IRBESARTAN/HCTZ	SAN
02365189	IRBESARTAN-HCTZ	PDL
02418258	JAMP-IRBESARTAN AND HYDROCHLOROTHIAZIDE	JMP
02393026	MINT-IRBESARTAN/HCTZ	MIN
02328534	PMS-IRBESARTAN-HCTZ	PMS
02363224	RAN-IRBESARTAN HCTZ	RBY
02330539	RATIO-IRBESARTAN HCTZ	TEV
02337444	SANDOZ IRBESARTAN HCT	SDZ
02316048	TEVA-IRBESARTAN/HCTZ	TEV

LOSARTAN POTASSIUM

ST **25MG TABLET**

02354829	ACT LOSARTAN	ACG
02379058	APO-LOSARTAN	APX
02403323	AURO-LOSARTAN	AUR
02445964	BIO-LOSARTAN	BMI
02182815	COZAAR	FRS
02398834	JAMP-LOSARTAN	JMP
02388790	LOSARTAN	SIV
02388863	LOSARTAN	SAN
02394367	LOSARTAN	PDL
02405733	MINT-LOSARTAN	MIN
02368277	MYLAN-LOSARTAN	MYL
02309750	PMS-LOSARTAN	PMS
02313332	SANDOZ LOSARTAN	SDZ
02424967	SEPTA-LOSARTAN	SPT
02380838	TEVA-LOSARTAN	TEV
02426595	VAN-LOSARTAN	VAN

ST **50MG TABLET**

02354837	ACT LOSARTAN	ACG
02353504	APO-LOSARTAN	APX
02403331	AURO-LOSARTAN	AUR
02445972	BIO-LOSARTAN	BMI

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

LOSARTAN POTASSIUM

50MG TABLET

02182874	COZAAR	FRS
02398842	JAMP-LOSARTAN	JMP
02388804	LOSARTAN	SIV
02388871	LOSARTAN	SAN
02394375	LOSARTAN	PDL
02405741	MINT-LOSARTAN	MIN
02368285	MYLAN-LOSARTAN	MYL
02309769	PMS-LOSARTAN	PMS
02404478	RAN-LOSARTAN	RBY
02313340	SANDOZ LOSARTAN	SDZ
02424975	SEPTA-LOSARTAN	SPT
02357968	TEVA-LOSARTAN	TEV
02426609	VAN-LOSARTAN	VAN

100MG TABLET

02354845	ACT LOSARTAN	ACG
02353512	APO-LOSARTAN	APX
02403358	AURO-LOSARTAN	AUR
02445980	BIO-LOSARTAN	BMI
02182882	COZAAR	FRS
02398850	JAMP-LOSARTAN	JMP
02388812	LOSARTAN	SIV
02388898	LOSARTAN	SAN
02394383	LOSARTAN	PDL
02405768	MINT-LOSARTAN	MIN
02368293	MYLAN-LOSARTAN	MYL
02309777	PMS-LOSARTAN	PMS
02404486	RAN-LOSARTAN	RBY
02313359	SANDOZ LOSARTAN	SDZ
02424983	SEPTA-LOSARTAN	SPT
02357976	TEVA-LOSARTAN	TEV
02426617	VAN-LOSARTAN	VAN

LOSARTAN POTASSIUM, HYDROCHLOROTHIAZIDE

50MG & 12.5MG TABLET

02388251	ACT LOSARTAN/HCT	ACG
02371235	APO-LOSARTAN/HCTZ	APX
02423642	AURO-LOSARTAN HCT	AUR
02230047	HYZAAR	FRS
02408244	JAMP-LOSARTAN HCTZ	JMP
02388960	LOSARTAN HCT	SIV
02427648	LOSARTAN/HCTZ	SAN
02394391	LOSARTAN-HCTZ	PDL
02389657	MINT-LOSARTAN/HCTZ	MIN
02378078	MYLAN-LOSARTAN HCTZ	MYL
02392224	PMS-LOSARTAN-HCTZ	PMS
02313375	SANDOZ LOSARTAN HCT	SDZ
02428539	SEPTA-LOSARTAN HCTZ	SPT
02358263	TEVA-LOSARTAN/HCTZ	TEV

100MG & 12.5MG TABLET

02388278	ACT LOSARTAN/HCT	ACG
02371243	APO-LOSARTAN/HCTZ	APX
02423650	AURO-LOSARTAN HCT	AUR

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

LOSARTAN POTASSIUM, HYDROCHLOROTHIAZIDE

100MG & 12.5MG TABLET

02297841	HYZAAR	FRS
02388979	LOSARTAN HCT	SIV
02427656	LOSARTAN/HCTZ	SAN
02394405	LOSARTAN-HCTZ	PDL
02389665	MINT-LOSARTAN/HCTZ	MIN
02378086	MYLAN-LOSARTAN HCTZ	MYL
02392232	PMS-LOSARTAN-HCTZ	PMS
02362449	SANDOZ LOSARTAN HCT	SDZ
02377144	TEVA-LOSARTAN/HCTZ	TEV

100MG & 25MG TABLET

02388286	ACT LOSARTAN/HCT	ACG
02371251	APO-LOSARTAN/HCTZ	APX
02423669	AURO-LOSARTAN HCT	AUR
02241007	HYZAAR DS	FRS
02408252	JAMP-LOSARTAN HCTZ	JMP
02388987	LOSARTAN HCT	SIV
02427664	LOSARTAN/HCTZ	SAN
02394413	LOSARTAN-HCTZ	PDL
02389673	MINT-LOSARTAN/HCTZ	MIN
02378094	MYLAN-LOSARTAN HCTZ	MYL
02392240	PMS-LOSARTAN-HCTZ	PMS
02313383	SANDOZ LOSARTAN HCT	SDZ
02428547	SEPTA-LOSARTAN HCTZ	SPT
02377152	TEVA-LOSARTAN/HCTZ	TEV

OLMESARTAN MEDOXOMIL

20MG TABLET

02442191	ACT OLMESARTAN	ACG
02453452	APO-OLMESARTAN	APX
02443864	AURO-OLMESARTAN	AUR
02461641	JAMP-OLMESARTAN	JMP
02318660	OLMETEC	FRS
02461307	PMS-OLMESARTAN	PMS
02443414	SANDOZ OLMESARTAN	SDZ

40MG TABLET

02442205	ACT OLMESARTAN	ACG
02453460	APO-OLMESARTAN	APX
02443872	AURO-OLMESARTAN	AUR
02461668	JAMP-OLMESARTAN	JMP
02318679	OLMETEC	FRS
02461315	PMS-OLMESARTAN	PMS
02443422	SANDOZ OLMESARTAN	SDZ

OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE

20MG & 12.5MG TABLET

02443112	ACT OLMESARTAN HCT	ACG
02453606	APO-OLMESARTAN/HCTZ	APX

20MG/12.5MG TABLET

02319616	OLMETEC PLUS	FRS

40MG & 12.5MG TABLET

02443120	ACT OLMESARTAN HCT	ACG
02453614	APO-OLMESARTAN/HCTZ	APX

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

OLMESARTAN MEDOXOMIL, HYDROCHLOROTHIAZIDE

40MG & 25MG TABLET

02443139	ACT OLMESARTAN HCT	ACG
02453622	APO-OLMESARTAN/HCTZ	APX

40MG/12.5MG TABLET

02319624	OLMETEC PLUS	FRS

40MG/25MG TABLET

02319632	OLMETEC PLUS	FRS

TELMISARTAN

40MG TABLET

02393247	ACT TELMISARTAN	ACG
02420082	APO-TELMISARTAN	APX
02453568	AURO-TELMISARTAN	AUR
02240769	MICARDIS	BOE
02376717	MYLAN-TELMISARTAN	MYL
02391236	PMS-TELMISARTAN	PMS
02375958	SANDOZ TELMISARTAN	SDZ
02388944	TELMISARTAN	SAN
02390345	TELMISARTAN	SIV
02395223	TELMISARTAN	PDL
02407485	TELMISARTAN	ACC
02432897	TELMISARTAN	PMS
02320177	TEVA-TELMISARTAN	TEV

80MG TABLET

02393255	ACT TELMISARTAN	ACG
02420090	APO-TELMISARTAN	APX
02453576	AURO-TELMISARTAN	AUR
02240770	MICARDIS	BOE
02376725	MYLAN-TELMISARTAN	MYL
02391244	PMS-TELMISARTAN	PMS
02375966	SANDOZ TELMISARTAN	SDZ
02388952	TELMISARTAN	SAN
02390353	TELMISARTAN	SIV
02395231	TELMISARTAN	PDL
02407493	TELMISARTAN	ACC
02432900	TELMISARTAN	PMS
02320185	TEVA-TELMISARTAN	TEV

TELMISARTAN, HYDROCHLOROTHIAZIDE

80MG & 12.5MG TABLET

02419114	ACH-TELMISARTAN HCTZ	ACC
02393263	ACT TELMISARTAN/HCT	ACG
02420023	APO-TELMISARTAN/HCTZ	APX
02456389	AURO-TELMISARTAN HCTZ	AUR
02244344	MICARDIS PLUS	BOE
02401665	PMS-TELMISARTAN-HCTZ	PMS
02393557	SANDOZ TELMISARTAN HCT	SDZ
02390302	TELMISARTAN HCTZ	SIV
02395355	TELMISARTAN/HCTZ	SAN
02395525	TELMISARTAN-HCTZ	PDL
02433214	TELMISARTAN-HCTZ	PMS
02330288	TEVA-TELMISARTAN HCTZ	TEV

80MG & 25MG TABLET

02419122	ACH-TELMISARTAN HCTZ	ACC

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

TELMISARTAN, HYDROCHLOROTHIAZIDE

80MG & 25MG TABLET

02393271	ACT TELMISARTAN/HCT	ACG
02420031	APO-TELMISARTAN/HCTZ	APX
02456397	AURO-TELMISARTAN HCTZ	AUR
02318709	MICARDIS PLUS	BOE
02393565	SANDOZ TELMISARTAN HCT	SDZ
02390310	TELMISARTAN HCTZ	SIV
02395363	TELMISARTAN/HCTZ	SAN
02395533	TELMISARTAN-HCTZ	PDL
02433222	TELMISARTAN-HCTZ	PMS
02379252	TEVA-TELMISARTAN HCTZ	TEV

VALSARTAN

80MG CAPSULE

02236808	DIOVAN	NVR

40MG TABLET

02337487	ACT VALSARTAN	ACG
02371510	APO-VALSARTAN	APX
02414201	AURO-VALSARTAN	AUR
02270528	DIOVAN	NVR
02383527	MYLAN-VALSARTAN	MYL
02312999	PMS-VALSARTAN	PMS
02363062	RAN-VALSARTAN	RBY
02425440	RIVA-VALSARTAN	RIV
02356740	SANDOZ VALSARTAN	SDZ
02356643	TEVA-VALSARTAN	TEV
02366940	VALSARTAN	SAN
02367726	VALSARTAN	PDL
02384523	VALSARTAN	SIV

80MG TABLET

02337495	ACT VALSARTAN	ACG
02371529	APO-VALSARTAN	APX
02414228	AURO-VALSARTAN	AUR
02244781	DIOVAN	NVR
02414147	DOM-VALSARTAN	DPC
02383535	MYLAN-VALSARTAN	MYL
02313006	PMS-VALSARTAN	PMS
02363100	RAN-VALSARTAN	RBY
02425459	RIVA-VALSARTAN	RIV
02356759	SANDOZ VALSARTAN	SDZ
02356651	TEVA-VALSARTAN	TEV
02366959	VALSARTAN	SAN
02367734	VALSARTAN	PDL
02384531	VALSARTAN	SIV

160MG TABLET

02337509	ACT VALSARTAN	ACG
02371537	APO-VALSARTAN	APX
02414236	AURO-VALSARTAN	AUR
02244782	DIOVAN	NVR
02313014	PMS-VALSARTAN	PMS
02363119	RAN-VALSARTAN	RBY
02425467	RIVA-VALSARTAN	RIV
02356767	SANDOZ VALSARTAN	SDZ
02356678	TEVA-VALSARTAN	TEV

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

VALSARTAN

160MG TABLET

02366967	VALSARTAN	SAN
02367742	VALSARTAN	PDL
02384558	VALSARTAN	SIV

320MG TABLET

02337517	ACT VALSARTAN	ACG
02371545	APO-VALSARTAN	APX
02414244	AURO-VALSARTAN	AUR
02289504	DIOVAN	NVR
02383551	MYLAN-VALSARTAN	MYL
02344564	PMS-VALSARTAN	PMS
02425475	RIVA-VALSARTAN	RIV
02356775	SANDOZ VALSARTAN	SDZ
02356686	TEVA-VALSARTAN	TEV
02366975	VALSARTAN	SAN
02367750	VALSARTAN	PDL
02384566	VALSARTAN	SIV

VALSARTAN, HYDROCHLOROTHIAZIDE

80MG & 12.5MG TABLET

02382547	APO-VALSARTAN/HCTZ	APX
02408112	AURO-VALSARTAN HCT	AUR
02241900	DIOVAN-HCT	NVR
02356694	SANDOZ VALSARTAN HCT	SDZ
02356996	TEVA-VALSARTAN/HCTZ	TEV
02367009	VALSARTAN HCT	SAN
02384736	VALSARTAN HCT	SIV
02367769	VALSARTAN-HCTZ	PDL

160MG & 12.5MG TABLET

02382555	APO-VALSARTAN/HCTZ	APX
02408120	AURO-VALSARTAN HCT	AUR
02241901	DIOVAN-HCT	NVR
02356708	SANDOZ VALSARTAN HCT	SDZ
02357003	TEVA-VALSARTAN/HCTZ	TEV
02367017	VALSARTAN HCT	SAN
02384744	VALSARTAN HCT	SIV
02367777	VALSARTAN-HCTZ	PDL

160MG & 25MG TABLET

02382563	APO-VALSARTAN/HCTZ	APX
02408139	AURO-VALSARTAN HCT	AUR
02246955	DIOVAN-HCT	NVR
02356716	SANDOZ VALSARTAN HCT	SDZ
02357011	TEVA-VALSARTAN/HCTZ	TEV
02367025	VALSARTAN HCT	SAN
02384752	VALSARTAN HCT	SIV
02367785	VALSARTAN-HCTZ	PDL

320MG & 12.5MG TABLET

02382571	APO-VALSARTAN/HCTZ	APX
02408147	AURO-VALSARTAN HCT	AUR
02308908	DIOVAN-HCT	NVR
02356724	SANDOZ VALSARTAN HCT	SDZ
02357038	TEVA-VALSARTAN/HCTZ	TEV
02367033	VALSARTAN HCT	SAN
02384760	VALSARTAN HCT	SIV

24:32.08 ANGIOTENSIN II RECEPTOR ANTAGONISTS

VALSARTAN, HYDROCHLOROTHIAZIDE

320MG & 25MG TABLET

02382598	APO-VALSARTAN/HCTZ	APX
02408155	AURO-VALSARTAN HCT	AUR
02308916	DIOVAN-HCT	NVR
02356732	SANDOZ VALSARTAN HCT	SDZ
02357046	TEVA-VALSARTAN/HCTZ	TEV
02367041	VALSARTAN HCT	SAN
02384779	VALSARTAN HCT	SIV

24:32.20 MINERALOCORTICOIDE (ALDOSTERONE) RECEPTOR ANTAGONISTS

EPLERENONE

Limited use benefit (prior approval required).

For the treatment of patients with New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction (with ejection fraction ≤ 35%), as an adjunct to standard therapy.

Note: Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin-receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or

25MG TABLET

02323052	INSPRA	PFI

50MG TABLET

02323060	INSPRA	PFI

HYDROCHLOROTHIAZIDE, SPIRONOLACTONE

PDIN FOR EXTEMPORANEOUS MIXTURE

99503009	ALDACTAZIDE ORAL LIQUID	UNK

SPIRONOLACTONE

25MG TABLET

00028606	ALDACTONE	PFI
00613215	TEVA-SPIRONOLACTONE	TEV

100MG TABLET

00285455	ALDACTONE	PFI
00613223	TEVA-SPIRONOLACTONE	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503001	SPIRONOLACTONE ORAL LIQUID	UNK

24:32.92

VALSARTAN, SACUBITRIL

Limited use benefit (prior approval required).

For the treatment of New York Heart Association (NYHA) class II or III heart failure if the following criteria are met:
- Must be initiated by a physician experienced in the treatment of heart failure; AND
- Left ventricular ejection fraction < 40%; AND
- NYHA class II to III symptoms despite at least four weeks of treatment with an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB); OR If your patient has a contraindication or intolerance to ACEI or ARBs;

AND
- Must be used in combination with a beta blocker and an aldosterone antagonist (if tolerated); OR If your patient has a contraindication or intolerance to beta blockers or aldosterone antagonists.

26MG & 24MG TABLET		
02446928	ENTRESTO	NVR
51MG & 49MG TABLET		
02446936	ENTRESTO	NVR
103MG & 97MG TABLET		
02446944	ENTRESTO	NVR

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

ACETYLSALICYLIC ACID

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

150MG SUPPOSITORY

00785547	ASA	PMS

650MG SUPPOSITORY

00582867	ASA	PMS

80MG TABLET

02269139	ACETYLSALICYLIC ACID	JMP
02295563	LOWPRIN	EUR
02202360	RIVASA	RIV

325MG TABLET

00472468	APO ASA	APX
00530336	ASA	VTH
02150328	ASPIRIN	BAY

80MG TABLET (CHEWABLE)

02009013	ASAPHEN	PMS
02280167	ASATAB	ODN
02250675	EURO-ASA	EUR
02296004	LOWPRIN	SDZ
02429950	M-ASA	MAN
02311518	PRO-AAS	PDL
02202352	RIVASA	RIV

81MG TABLET (CHEWABLE)

02394790	ASA DAILY LOW DOSE	PMS
02243974	ENTROPHEN	PED

80MG TABLET (DELAYED RELEASE)

02427176	ASA EC	SAN
02238545	ASAPHEN	PMS
02283905	JAMP-ASA	JMP
02311496	PRO-AAS	PDL

81MG TABLET (DELAYED RELEASE)

02461471	APO-ASA LD	APX
02244993	ASA	PMS
02372177	ASA	VTH
02433044	ASA	PMS
02449277	ASA	TLI
02243101	ASA DAILY LOW DOSE	PMS
02377683	ASA DAILY LOW DOSE	APX
02426811	ASA EC	SAN
02242281	ENTROPHEN	PED
02283700	PRAXIS ASA DAILY LOW DOSE	PMS
02420279	RIVASA EC	RIV

162MG TABLET (DELAYED RELEASE)

02247550	ASAPHEN EC	PMS

325MG TABLET (DELAYED RELEASE)

02010526	ASA	VTH
02352427	ASATAB EC	ODN
02150417	ASPIRIN	BAY
00010332	ENTROPHEN	PED

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

ACETYLSALICYLIC ACID

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

325MG TABLET (DELAYED RELEASE)

02050161	ENTROPHEN	PED
00216666	NOVASEN	TEV
02284529	PMS-ASA EC	PMS

650MG TABLET (DELAYED RELEASE)

00794244	ASA	VTH
02352435	ASATAB EC	ODN
00229296	NOVASEN	TEV
02284537	PMS-ASA EC	PMS

81MG TABLET (ENTERIC COATED)

02243896	ASA DAILY LOW DOSE	PMS
02237726	ASPIRIN	BAY
02243801	EQUATE DAILY LOW-DOSE	PMS
02427206	JAMP-ASA EC	VTH

325MG TABLET (ENTERIC COATED)

00510696	ASA	APX
02285371	PMS-ASA EC	PMS

650MG TABLET (ENTERIC COATED)

00472476	ASA	APX
00010340	ENTROPHEN	PED
01905392	ENTROPHEN	PED

CELECOXIB

Limited use benefit (prior approval required).

For patients who have:
- A history of serious gastrointestinal complications (e.g. ulcer, bleeding, and perforation); OR
- Multiple (at least two) risk factors for serious gastrointestinal complications (e.g. age >60, concurrent use of ASA, SSRIs, corticosteroids, anticoagulants or antiplatelet agents).

100MG CAPSULE

02435632	ACCEL-CELECOXIB	ACP
02420155	ACT CELECOXIB	ACG
02418932	APO-CELECOXIB	APX
02445670	AURO-CELECOXIB	AUR
02426382	BIO-CELECOXIB	BMI
02239941	CELEBREX	PFI
02424371	CELECOXIB	PDL
02429675	CELECOXIB	SIV
02436299	CELECOXIB	SAN
02291975	GD-CELECOXIB	PFI
02424533	JAMP-CELECOXIB	JMP
02420058	MAR-CELECOXIB	MAR
02412497	MINT-CELECOXIB	MIN
02423278	MYLAN-CELECOXIB	MYL
02355442	PMS-CELECOXIB	PMS
02426366	PRIVA-CELECOXIB	PHA
02412373	RAN-CELECOXIB	RBY
02425386	RIVA-CELECOX	RIV
02321246	SANDOZ CELECOXIB	SDZ

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

CELECOXIB

Limited use benefit (prior approval required).

For patients who have:
- A history of serious gastrointestinal complications (e.g. ulcer, bleeding, and perforation); OR
- Multiple (at least two) risk factors for serious gastrointestinal complications (e.g. age >60, concurrent use of ASA, SSRIs, corticosteroids, anticoagulants or antiplatelet agents).

ST **100MG CAPSULE**

02442639	SDZ CELECOXIB	SDZ
02288915	TEVA-CELECOXIB	TEV

ST **200MG CAPSULE**

02435640	ACCEL-CELECOXIB	ACP
02420163	ACT CELECOXIB	ACG
02418940	APO-CELECOXIB	APX
02445689	AURO-CELECOXIB	AUR
02426390	BIO-CELECOXIB	BMI
02239942	CELEBREX	PFI
02424398	CELECOXIB	PDL
02429683	CELECOXIB	SIV
02436302	CELECOXIB	SAN
02291983	GD-CELECOXIB	PFI
02424541	JAMP-CELECOXIB	JMP
02420066	MAR-CELECOXIB	MAR
02412500	MINT-CELECOXIB	MIN
02399881	MYLAN-CELECOXIB	MYL
02355450	PMS-CELECOXIB	PMS
02426374	PRIVA-CELECOXIB	PHA
02412381	RAN-CELECOXIB	RBY
02425394	RIVA-CELECOX	RIV
02321254	SANDOZ CELECOXIB	SDZ
02442647	SDZ CELECOXIB	SDZ
02288923	TEVA-CELECOXIB	TEV

DICLOFENAC SODIUM

50MG SUPPOSITORY

02231506	PMS-DICLOFENAC	PMS
02261928	SANDOZ-DICLOFENAC	SDZ
00632724	VOLTAREN	NVR

100MG SUPPOSITORY

02231508	PMS-DICLOFENAC	PMS
02261936	SANDOZ-DICLOFENAC	SDZ
00632732	VOLTAREN	NVR

ST **25MG TABLET (DELAYED RELEASE)**

02231662	DOM-DICLOFENAC	DPC
02302616	PMS-DICLOFENAC	PMS

ST **50MG TABLET (DELAYED RELEASE)**

02231663	DOM-DICLOFENAC	DPC
02302624	PMS-DICLOFENAC	PMS
02261960	SANDOZ-DICLOFENAC	SDZ
00514012	VOLTAREN	NVR

ST **25MG TABLET (ENTERIC COATED)**

00839175	APO-DICLO	APX
02231502	PMS-DICLOFENAC	PMS
00808539	TEVA-DICLOFENAC	TEV

DICLOFENAC SODIUM

ST **50MG TABLET (ENTERIC COATED)**

00839183	APO-DICLO	APX
00870978	DICLOFENAC	PDL
02352397	DICLOFENAC EC	SAN
02231503	PMS-DICLOFENAC	PMS
00808547	TEVA-DICLOFENAC	TEV

ST **75MG TABLET (EXTENDED RELEASE)**

02162814	APO-DICLO SR	APX
02224119	DICLOFENAC-SR	PDL
02231664	DOM-DICLOFENAC SR	DPC
02231504	PMS-DICLOFENAC	PMS
02261901	SANDOZ-DICLOFENAC SR	SDZ
02158582	TEVA-DICLOFENAC SR	TEV
00782459	VOLTAREN	NVR

ST **100MG TABLET (EXTENDED RELEASE)**

02091194	APO-DICLO SR	APX
02224127	DICLOFENAC-SR	PDL
02231505	PMS-DICLOFENAC	PMS
02261944	SANDOZ-DICLOFENAC SR	SDZ
02048698	TEVA-DICLOFENAC SR	TEV
00590827	VOLTAREN SR	NVR

DICLOFENAC SODIUM (TOPICAL)

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:
- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

ST **1.5% SOLUTION**

02354403	APO-DICLOFENAC	APX
02434571	DICLOFENAC TOPICAL	RAX
02356783	PMS-DICLOFENAC	PMS
02420988	TARO-DICLOFENAC	TAR

DIFLUNISAL

ST **250MG TABLET**

02039486	DIFLUNISAL	AAP
02048493	NOVO-DIFLUNISAL	TEV

ST **500MG TABLET**

02039494	DIFLUNISAL	AAP

FLURBIPROFEN

ST **50MG TABLET**

01912046	APO-FLURBIPROFEN	APX
02100509	TEVA-FLURBIPROFEN	TEV

ST **100MG TABLET**

01912038	APO-FLURBIPROFEN	APX
02100517	TEVA-FLURBIPROFEN	TEV

IBUPROFEN

ST **20MG/ML SUSPENSION**

02232297	CHILDREN'S ADVIL	PFI
02354799	CHILDREN'S EUROPROFEN	PED
02242365	CHILDREN'S MOTRIN	MCL

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

IBUPROFEN

40MG/ML SUSPENSION

02242522	ADVIL PEDIATRIC DROPS	PFI
02238626	CHILDREN'S MOTRIN	MCL

100MG TABLET

02246403	ADVIL	PFI

200MG TABLET

01933558	ADVIL	PFI
00441643	APO-IBUPROFEN	APX
02257912	IBUPROFEN	PMT
02272849	IBUPROFEN	VTH
02314754	IBUPROFEN	PMS
02314762	IBUPROFEN	PMS
02368072	IBUPROFEN	VTH
02186934	MOTRIN	MCL
00629324	NOVO-PROFEN	TEV

300MG TABLET

00441651	APO IBUPROFEN	APX
00629332	NOVO-PROFEN	TEV

400MG TABLET

00506052	APO IBUPROFEN	APX
00636533	IBUPROFEN	PDL
02314770	IBUPROFEN	PMS
02317338	IBUPROFEN	PMT
02401290	JAMP-IBUPROFEN	JMP
00629340	NOVO-PROFEN	TEV
00836133	PMS-IBUPROFEN	PMS

600MG TABLET

00585114	APO IBUPROFEN	APX
00629359	TEVA-PROFEN	TEV

INDOMETHACIN

25MG CAPSULE

00611158	APO INDOMETHACIN	APX
02461811	MINT-INDOMETHACIN	MIN
00337420	TEVA-INDOMETHACIN	TEV

50MG CAPSULE

00611166	APO INDOMETHACIN	APX
02461536	MINT-INDOMETHACIN	MIN
00337439	TEVA-INDOMETHACIN	TEV

50MG SUPPOSITORY

02231799	SANDOZ INDOMETHACIN	SDZ

100MG SUPPOSITORY

01934139	RATIO-INDOMETHACIN	TEV
02231800	SANDOZ INDOMETHACIN	SDZ

KETOPROFEN

50MG CAPSULE

00790427	KETOPROFEN	AAP
02150808	PMS-KETOPROFEN	PMS

100MG SUPPOSITORY

02015951	PMS-KETOPROFEN	PMS

50MG TABLET (ENTERIC COATED)

00790435	KETOPROFEN-E	AAP
02150816	PMS-KETOPROFEN	PMS

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

KETOPROFEN

100MG TABLET (ENTERIC COATED)

00842664	KETOPROFEN-E	AAP
02150824	PMS-KETOPROFEN	PMS

200MG TABLET (EXTENDED RELEASE)

02172577	KETOPROFEN SR	AAP

MEFENAMIC ACID

250MG CAPSULE

02237826	DOM-MEFENAMIC ACID	DPC
02229452	MEFENAMIC	AAP
00155225	PONSTAN	AAP

MELOXICAM

7.5MG TABLET

02250012	ACT MELOXICAM	TEV
02248973	APO-MELOXICAM	APX
02390884	AURO-MELOXICAM	AUR
02248605	DOM-MELOXICAM	DPC
02324326	MELOXICAM	PDL
02353148	MELOXICAM	SAN
02242785	MOBICOX	BOE
02255987	MYLAN-MELOXICAM	MYL
02248267	PMS-MELOXICAM	PMS
02258315	TEVA-MELOXICAM	TEV

15MG TABLET

02250020	ACT MELOXICAM	TEV
02248974	APO-MELOXICAM	APX
02390892	AURO-MELOXICAM	AUR
02248606	DOM-MELOXICAM	DPC
02324334	MELOXICAM	PDL
02353156	MELOXICAM	SAN
02242786	MOBICOX	BOE
02255995	MYLAN-MELOXICAM	MYL
02248268	PMS-MELOXICAM	PMS
02258323	TEVA-MELOXICAM	TEV

MISOPROSTOL, DICLOFENAC SODIUM

200MCG & 50MG TABLET

02400596	SANDOZ DICLOFENAC MISOPROSTOL	SDZ

200MCG & 75MG TABLET

02400618	SANDOZ DICLOFENAC MISOPROSTOL	SDZ

200MCG & 50MG TABLET (DELAYED RELEASE)

01917056	ARTHROTEC	PFI
02341689	GD-DICLOFENAC/MISOPROSTOL	PFI

200MCG & 75MG TABLET (DELAYED RELEASE)

02229837	ARTHROTEC	PFI
02341697	GD-DICLOFENAC/MISOPROSTOL	PFI

200MCG & 50MG TABLET (ENTERIC COATED)

02397145	ACT DICLO-MISO	ACG

200MCG & 75MG TABLET (ENTERIC COATED)

02397153	ACT DICLO-MISO	ACG

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

NAPROXEN

500MG SUPPOSITORY

02017237	PMS-NAPROXEN	PMS

ST **25MG/ML SUSPENSION**

02162431	NAPROXEN	PEI

ST **125MG TABLET**

00522678	APO NAPROXEN	APX

ST **220MG TABLET**

02362430	NAPROXEN	PMS
02385007	NAPROXEN SODIUM	APX

ST **250MG TABLET**

00522651	APO-NAPROXEN	APX
00590762	NAPROXEN	PDL
02350750	NAPROXEN	SAN
00565350	TEVA-NAPROXEN	TEV

ST **275MG TABLET**

02162725	ANAPROX	APU
00784354	APO-NAPRO-NA	APX
02351013	NAPROXEN SODIUM	SAN
00887056	NAPROXEN-NA	PDL
00778389	TEVA-NAPROXEN	TEV

ST **375MG TABLET**

00600806	APO-NAPROXEN	APX
00655686	NAPROXEN	PDL
02350769	NAPROXEN	SAN
00627097	TEVA-NAPROXEN	TEV

ST **500MG TABLET**

00592277	APO-NAPROXEN	APX
00618721	NAPROXEN	PDL
02350777	NAPROXEN	SAN
00589861	TEVA-NAPROXEN	TEV

ST **550MG TABLET**

02162717	ANAPROX DS	APU
01940309	APO-NAPRO-NA DS	APX
02351021	NAPROXEN SODIUM DS	SAN
02153386	NAPROXEN-NA DF	PDL
02026600	TEVA-NAPROXEN DS	TEV

ST **250MG TABLET (ENTERIC COATED)**

02246699	APO-NAPROXEN EC	APX
02350785	NAPROXEN EC	SAN
02243312	TEVA-NAPROXEN	TEV

ST **375MG TABLET (ENTERIC COATED)**

02246700	APO-NAPROXEN EC	APX
02243432	MYLAN-NAPROXEN	MYL
02162415	NAPROSYN	APU
02350793	NAPROXEN EC	SAN
02294702	PMS-NAPROXEN EC	PMS
02310945	PRO-NAPROXEN	PDL
02243313	TEVA-NAPROXEN	TEV

ST **500MG TABLET (ENTERIC COATED)**

02246701	APO-NAPROXEN EC	APX
02241024	MYLAN-NAPROXEN EC	MYL
02162423	NAPROSYN	APU
02350807	NAPROXEN EC	SAN
02294710	PMS-NAPROXEN EC	PMS

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

NAPROXEN

ST **500MG TABLET (ENTERIC COATED)**

02310953	PRO-NAPROXEN	PDL
02243314	TEVA-NAPROXEN	TEV

ST **750MG TABLET (EXTENDED RELEASE)**

02162466	NAPROSYN	APU

PIROXICAM

ST **10MG CAPSULE**

00642886	APO PIROXICAM	APX
00695718	TEVA-PIROXICAM	TEV

ST **20MG CAPSULE**

00642894	APO PIROXICAM	APX
00695696	TEVA-PIROXICAM	TEV

SULINDAC

ST **150MG TABLET**

00745588	TEVA-SULINDAC	TEV

ST **200MG TABLET**

00745596	TEVA-SULINDAC	TEV

TIAPROFENIC ACID

ST **200MG TABLET**

02230827	PMS-TIAPROFENIC	PMS
02179679	TEVA-TIAPROFENIC	TEV

ST **300MG TABLET**

02231060	DOM-TIAPROFENIC	DPC
02179687	TEVA-TIAPROFENIC	TEV

28:08.08 OPIATE AGONISTS

ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

300MG & 15MG & 15MG TABLET

00653241	RATIO-LENOLTEC NO 2	TEV
02163934	TYLENOL WITH CODEINE NO.2	JSO

300MG & 15MG & 30MG TABLET

00653276	RATIO-LENOLTEC NO 3	TEV
02163926	TYLENOL WITH CODEINE NO.3	JSO

325MG & 30MG & 15MG TABLET

00293504	ATASOL 15	CHU

325MG & 30MG & 30MG TABLET

00293512	ATASOL 30	CHU

28:08.08 OPIATE AGONISTS

ACETAMINOPHEN, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

32MG & 1.6MG/ML ELIXIR

00816027	PMS-ACETAMINOPHEN	PMS

300MG & 30MG TABLET

01999648	ACET CODEINE 30	PMS
02232658	PROCET-30	PDL
00608882	TEVA-EMTEC-30	TEV
00789828	TRIATEC-30	RIV

ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

325MG & 5MG TABLET

02324628	APO-OXYCODONE/ACET	APX
02361361	OXYCODONE/ACET	SAN
02327171	OXYCODONE-ACET	PDL
02242468	RIVACOCET	RIV
02307898	SANDOZ OXYCODONE/ACETAMINOPHEN	SDZ
00608165	TEVA-OXYCOCET	TEV

ACETYLSALICYLIC ACID, OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157	TEVA-OXYCODAN	TEV

28:08.08 OPIATE AGONISTS

CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:
- chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
- chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

50MG TABLET (EXTENDED RELEASE)

02230302	CODEINE CONTIN CR	PFR

100MG TABLET (EXTENDED RELEASE)

02163748	CODEINE CONTIN CR	PFR

150MG TABLET (EXTENDED RELEASE)

02163780	CODEINE CONTIN CR	PFR

200MG TABLET (EXTENDED RELEASE)

02163799	CODEINE CONTIN CR	PFR

CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

5MG/ML LIQUID

00050024	CODEINE PHOSPHATE	ATL

2MG/ML SOLUTION

00380571	LINCTUS CODEINE	ATL

15MG TABLET

02009889	CODEINE	RIV
00593435	TEVA-CODEINE	TEV

30MG TABLET

02009757	CODEINE	RIV
02243979	PMS-CODEINE	PMS
00593451	TEVA-CODEINE	TEV

28:08.08 OPIATE AGONISTS

FENTANYL

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

12MCG/HR PATCH

02386844	CO FENTANYL	OBT
02395657	FENTANYL	PDL
02396696	MYLAN-FENTANYL MATRIX	MYL
02341379	PMS-FENTANYL MTX	PMS
02330105	RAN-FENTANYL MATRIX	RBY
02327112	SANDOZ FENTANYL	SDZ
02311925	TEVA-FENTANYL	TEV

25MCG/HR PATCH

02314630	APO-FENTANYL MATRIX	APX
02386852	CO FENTANYL	OBT
02275813	DURAGESIC	JSO
02395665	FENTANYL	PDL
02396718	MYLAN-FENTANYL MATRIX	MYL
02341387	PMS-FENTANYL MTX	PMS
02330113	RAN-FENTANYL MATRIX	RBY
02327120	SANDOZ FENTANYL	SDZ
02282941	TEVA-FENTANYL	TEV

50MCG/HR PATCH

02314649	APO-FENTANYL MATRIX	APX
02386879	CO FENTANYL	OBT
02275821	DURAGESIC	JSO
02395673	FENTANYL	PDL
02396726	MYLAN-FENTANYL MATRIX	MYL
02341395	PMS-FENTANYL MTX	PMS
02330121	RAN-FENTANYL MATRIX	RBY
02327147	SANDOZ FENTANYL	SDZ
02282968	TEVA-FENTANYL	TEV

75MCG/HR PATCH

02314657	APO-FENTANYL MATRIX	APX
02386887	CO FENTANYL	OBT
02275848	DURAGESIC	JSO
02395681	FENTANYL	PDL
02396734	MYLAN-FENTANYL MATRIX	MYL
02341409	PMS-FENTANYL MTX	PMS
02330148	RAN-FENTANYL MATRIX	RBY
02327155	SANDOZ FENTANYL	SDZ
02282976	TEVA-FENTANYL	TEV

100MCG/HR PATCH

02314665	APO-FENTANYL MATRIX	APX
02386895	CO FENTANYL	OBT
02275856	DURAGESIC	JSO
02395703	FENTANYL	PDL

28:08.08 OPIATE AGONISTS

FENTANYL

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

100MCG/HR PATCH

02396742	MYLAN-FENTANYL MATRIX	MYL
02341417	PMS-FENTANYL MTX	PMS
02330156	RAN-FENTANYL MATRIX	RBY
02327163	SANDOZ FENTANYL	SDZ
02282984	TEVA-FENTANYL	TEV

HYDROMORPHONE HYDROCHLORIDE

Limited use benefit.
Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

3MG CAPSULE (SUSTAINED RELEASE)

02125323	HYDROMORPH CONTIN	PFR

4.5MG CAPSULE (SUSTAINED RELEASE)

02359502	HYDROMORPH CONTIN	PFR

6MG CAPSULE (SUSTAINED RELEASE)

02125331	HYDROMORPH CONTIN	PFR

9MG CAPSULE (SUSTAINED RELEASE)

02359510	HYDROMORPH CONTIN	PFR

12MG CAPSULE (SUSTAINED RELEASE)

02125366	HYDROMORPH CONTIN	PFR

18MG CAPSULE (SUSTAINED RELEASE)

02243562	HYDROMORPH CONTIN	PFR

24MG CAPSULE (SUSTAINED RELEASE)

02125382	HYDROMORPH CONTIN	PFR

30MG CAPSULE (SUSTAINED RELEASE)

02125390	HYDROMORPH CONTIN	PFR

1MG/ML LIQUID

00786535	DILAUDID	PFR
01916386	PMS HYDROMORPHONE	PMS

3MG SUPPOSITORY

01916394	PMS HYDROMORPHONE	PMS

1MG TABLET

02364115	APO-HYDROMORPHONE	APX

28:08.08 OPIATE AGONISTS

HYDROMORPHONE HYDROCHLORIDE

Limited use benefit.
Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

1MG TABLET

00705438	DILAUDID	PFR
00885444	PMS-HYDROMORPHONE	PMS
02319403	TEVA-HYDROMORPHONE	TEV

2MG TABLET

02364123	APO-HYDROMORPHONE	APX
00125083	DILAUDID	PFR
00885436	PMS-HYDROMORPHONE	PMS
02319411	TEVA-HYDROMORPHONE	TEV

4MG TABLET

02364131	APO-HYDROMORPHONE	APX
00125121	DILAUDID	PFR
00885401	PMS-HYDROMORPHONE	PMS
02319438	TEVA-HYDROMORPHONE	TEV

8MG TABLET

02364158	APO-HYDROMORPHONE	APX
00786543	DILAUDID	PFR
00885428	PMS-HYDROMORPHONE	PMS
02319446	TEVA-HYDROMORPHONE	TEV

METHADONE HYDROCHLORIDE

POWDER

00908835	METHADONE POWDER (OAT)	MDS

10MG/ML SOLUTION

02244290	METADOL-D	PAL
02394596	METHADOSE	MAT
02394618	METHADOSE	MAT

METHADONE HYDROCHLORIDE (BC ONLY)

10MG/ML ORAL LIQUID

66999999	METHADOSE DEL. W DIRECT INTER (OAT)	UNK
67000000	METHADOSE DEL. W/OUT DIR INTER (OAT)	UNK
66999997	METHADOSE W DIRECT INTERACTION (OAT)	UNK
66999998	METHADOSE W/OUT DIRECT INTER (OAT)	UNK

28:08.08 OPIATE AGONISTS

METHADONE HYDROCHLORIDE (METADOL)

Limited use benefit (prior approval required) with the following criteria:

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND
For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR
For the management of pain for palliative care patients.
Pharmacists may only dispense a maximum supply of 30 days at one time.

1MG/ML SOLUTION

02247694	METADOL	PAL

10MG/ML SOLUTION

02241377	METADOL	PAL

1MG TABLET

02247698	METADOL	PAL

5MG TABLET

02247699	METADOL	PAL

10MG TABLET

02247700	METADOL	PAL

25MG TABLET

02247701	METADOL	PAL

MORPHINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

1MG/ML SYRUP

00614491	DOLORAL 1	ATL
00607762	RATIO-MORPHINE	TEV

5MG/ML SYRUP

00614505	DOLORAL 5	ATL
00607770	RATIO-MORPHINE	TEV

10MG/ML SYRUP

00690783	RATIO-MORPHINE	TEV

20MG/ML SYRUP

00690791	RATIO-MORPHINE	TEV

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPSULE (EXTENDED RELEASE)

02019930	M-ESLON	ETH

15MG CAPSULE (EXTENDED RELEASE)

02177749	M-ESLON	ETH

30MG CAPSULE (EXTENDED RELEASE)

02019949	M-ESLON	ETH

28:08.08 OPIATE AGONISTS

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

60MG CAPSULE (EXTENDED RELEASE)		
02019957	M-ESLON	ETH
100MG CAPSULE (EXTENDED RELEASE)		
02019965	M-ESLON	ETH
200MG CAPSULE (EXTENDED RELEASE)		
02177757	M-ESLON	ETH
20MG/ML DROP		
00621935	STATEX	PAL
50MG/ML DROP		
00705799	STATEX	PAL
5MG SUPPOSITORY		
00632228	STATEX	PAL
10MG SUPPOSITORY		
00632201	STATEX	PAL
20MG SUPPOSITORY		
00596965	STATEX	PAL
1MG/ML SYRUP		
00591467	STATEX	PAL
5MG/ML SYRUP		
00591475	STATEX	PAL
10MG/ML SYRUP		
00647217	STATEX	PAL
5MG TABLET		
00594652	STATEX	PAL
10MG TABLET		
00594644	STATEX	PAL
25MG TABLET		
00594636	STATEX	PAL
50MG TABLET		
00675962	STATEX	PAL
15MG TABLET (EXTENDED RELEASE)		
02350815	MORPHINE SR	SAN
02015439	MS CONTIN SR	PFR
02244790	SANDOZ MORPHINE SR	SDZ
02302764	TEVA-MORPHINE SR	TEV
30MG TABLET (EXTENDED RELEASE)		
02350890	MORPHINE SR	SAN
02014297	MS CONTIN SR	PFR
02244791	SANDOZ MORPHINE SR	SDZ
02302772	TEVA-MORPHINE SR	TEV
60MG TABLET (EXTENDED RELEASE)		
02350912	MORPHINE SR	SAN
02014300	MS CONTIN SR	PFR
02244792	SANDOZ MORPHINE SR	SDZ
02302780	TEVA-MORPHINE SR	TEV
100MG TABLET (EXTENDED RELEASE)		
02014319	MS CONTIN SR	PFR
02302799	TEVA-MORPHINE SR	TEV

28:08.08 OPIATE AGONISTS

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

200MG TABLET (EXTENDED RELEASE)		
02014327	MS CONTIN SR	PFR
02302802	TEVA-MORPHINE SR	TEV
5MG TABLET (IMMEDIATE RELEASE)		
02014203	MS IR	PFR
10MG TABLET (IMMEDIATE RELEASE)		
02014211	MS IR	PFR
20MG TABLET (IMMEDIATE RELEASE)		
02014238	MS IR	PFR
30MG TABLET (IMMEDIATE RELEASE)		
02014254	MS IR	PFR

MORPHINE SULFATE (KADIAN)

Limited use benefit (prior approval required).

- For the treatment of opioid dependence where methadone and Suboxone are not available or not appropriate; OR
- For the treatment of chronic pain.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPSULE (SUSTAINED RELEASE)		
02242163	KADIAN	BGP
09991310	KADIAN	MAY
20MG CAPSULE (SUSTAINED RELEASE)		
02184435	KADIAN	BGP
09991311	KADIAN	MAY
50MG CAPSULE (SUSTAINED RELEASE)		
02184443	KADIAN	BGP
09991312	KADIAN	MAY
100MG CAPSULE (SUSTAINED RELEASE)		
02184451	KADIAN	BGP
09991313	KADIAN	MAY

OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG SUPPOSITORY		
00392480	SUPEUDOL	SDZ
20MG SUPPOSITORY		
00392472	SUPEUDOL	SDZ
5MG TABLET		
02325950	OXYCODONE	PDL

28:08.08 OPIATE AGONISTS

OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

5MG TABLET

02231934	OXY-IR	PFR
02319977	PMS-OXYCODONE	PMS
00789739	SUPEUDOL	SDZ

10MG TABLET

02325969	OXYCODONE	PDL
02240131	OXY-IR	PFR
02319985	PMS-OXYCODONE	PMS
00443948	SUPEUDOL	SDZ

20MG TABLET

02325977	OXYCODONE	PDL
02319993	PMS-OXYCODONE	PMS
02262983	SUPEUDOL	SDZ

20MG TABLET (IMMEDIATE RELEASE)

02240132	OXY-IR	PFR

28:08.12 OPIATE PARTIAL AGONISTS

BUPRENORPHINE HYDROCHLORIDE, NALOXONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of opioid dependence when:
- The client must be 16 years or older.
- In cases where the client lives in a remote or isolated location, confirmation is required that the community has the ability to support Suboxone administration. These supports include the safe daily witnessing, storage and handling of the Suboxone doses. After this confirmation, NIHB will approve the Suboxone for the client.

2MG & 0.5MG TABLET

02408090	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424851	PMS-BUPRENORPHINE-NALOXONE	PMS
02295695	SUBOXONE	IND

8MG & 2MG TABLET

02408104	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424878	PMS-BUPRENORPHINE-NALOXONE	PMS
02295709	SUBOXONE	IND

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

80MG/ML DROP

02027801	PEDIATRIX	TEV
00875988	TEMPRA INFANT	PAL

16MG/ML LIQUID

01905848	ACETAMINOPHEN	TLI
00792713	PDP-ACETAMINOPHEN	PED
02263807	PEDIAPHEN	EUR
00884553	TEMPRA CHILDREN'S	PAL

32MG/ML LIQUID

01901389	ACETAMINOPHEN	JMP
01958836	ACETAMINOPHEN	TLI
00792691	PDP-ACETAMINOPHEN	PED
02263831	PEDIAPHEN	EUR
02027798	PEDIATRIX	TEV
00875996	TEMPRA CHILDREN'S DOUBLE STRENGTH	PAL
02046040	TYLENOL	MCL

80MG/ML ORAL LIQUID

01905864	ACETAMINOPHEN	TLI
02046059	TYLENOL	MCL

80MG/ML SOLUTION

01904140	ACETAMINOPHEN	TAN
02237390	ACETAMINOPHEN	PER
00887587	PDP-ACETAMINOPHEN	PED
02263793	PEDIAPHEN	EUR

120MG SUPPOSITORY

00553328	ABENOL	GSK
01919385	ABENOL	PED
02230434	ACET 120	PED
02046660	PMS-ACETAMINOPHEN	PMS

160MG SUPPOSITORY

02230435	ACET	PED

325MG SUPPOSITORY

01919393	ABENOL	PED
02230436	ACET 325	PED
02046687	PMS-ACETAMINOPHEN	PMS

650MG SUPPOSITORY

01919407	ABENOL	PED
02230437	ACET 650	PED
02046695	PMS-ACETAMINOPHEN	PMS

80MG TABLET

01905856	ACETAMINOPHEN	TLI
02015676	ACETAMINOPHEN	TAN
02263815	PEDIAPHEN	EUR
02238295	TYLENOL JR STRENGTH FASTMELTS	MCL

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

160MG TABLET

02017431	ACETAMINOPHEN	RIV
02230934	ACETAMINOPHEN	TAN

325MG TABLET

00382752	ACETAMINOPHEN	PDL
00605751	ACETAMINOPHEN	VTH
00743542	ACETAMINOPHEN	PMT
00789801	ACETAMINOPHEN	TLI
01938088	ACETAMINOPHEN	JMP
02022214	ACÉTAMINOPHÈNE	RIV
02362198	ACÉTAMINOPHÈNE	RIV
00544981	APO ACETAMINOPHEN	APX
02229873	APO-ACETAMINOPHEN	APX
02451018	M-ACETAMINOPHEN	MAN
00389218	NOVO-GESIC	TEV
00559393	TYLENOL	MCL
00723894	TYLENOL	MCL

500MG TABLET

00386626	ACETAMINOPHEN	PDL
00549703	ACETAMINOPHEN	PMT
00605778	ACETAMINOPHEN	VTH
00789798	ACETAMINOPHEN	TLI
01939122	ACETAMINOPHEN	JMP
01962353	ACETAMINOPHEN	TAN
02252813	ACETAMINOPHEN	PMT
02255251	ACETAMINOPHEN	PMT
02022222	ACÉTAMINOPHÈNE	RIV
02362228	ACÉTAMINOPHÈNE	RIV
02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007	APO ACETAMINOPHEN	APX
02229977	APO-ACETAMINOPHEN	APX
00013668	ATASOL FORTE	CHU
02355299	JAMP ACETAMINOPHEN BLAZON	JMP
02451123	M-ACETAMINOPHEN	MAN
00482323	NOVO-GESIC FORTE	TEV
00892505	PMS-ACETAMINOPHEN	PMS
00723908	TYLENOL	MCL
00559407	TYLENOL EXTRA STRENGTH	MCL

80MG TABLET (CHEWABLE)

02017458	ACETAMINOPHEN	RIV
02129957	ACETAMINOPHEN	VTH

160MG TABLET (CHEWABLE)

02142805	ACETAMINOPHEN	VTH
02263823	PEDIAPHEN	EUR

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

160MG TABLET (CHEWABLE)

02347792	TYLENOL JR STRENGTH FASTMELTS	MCL
02241361	TYLENOL JUNIOR STRENGTH	MCL

FLOCTAFENINE

200MG TABLET

02244680	FLOCTAFENINE	AAP

400MG TABLET

02244681	FLOCTAFENINE	AAP

28:10.00 OPIATE ANTAGONISTS

NALOXONE HYDROCHLORIDE

INJECTION

09991488	NALOXONE KIT	UNK

0.4MG/ML INJECTION

09991460	NALOXONE KIT	UNK

0.4MG SOLUTION

02453258	S.O.S NALOXONE HYDROCHLORIDE	SDZ

0.4MG/ML SOLUTION

02148706	NALOXONE	SDZ
02382482	NALOXONE	TEL
02382601	NALOXONE	SDZ
02393034	NALOXONE	OMG

1MG/ML SOLUTION

02148714	NALOXONE	SDZ
02393042	NALOXONE	OMG

NALTREXONE HYDROCHLORIDE

50MG TABLET

02444275	APO-NALTREXONE	APX
02451883	NALTREXONE HYDROCHLORIDE	UNK
02213826	REVIA	TEV

28:12.04 ANTICONVULSANTS - BARBITURATES

PHENOBARBITAL

5MG/ML ELIXIR

00645575	PHENOBARB	PED

100MG TABLET

00178829	PHENOBARB	PED

PRIMIDONE

125MG TABLET

00399310	PRIMIDONE	AAP

28:12.04 ANTICONVULSANTS - BARBITURATES

PRIMIDONE

250MG TABLET

00396761	PRIMIDONE	AAP

28:12.08 ANTICONVULSANTS - BENZODIAZEPINES

CLOBAZAM

10MG TABLET

02244638	APO-CLOBAZAM	APX
02221799	FRISIUM	LUK
02244474	PMS-CLOBAZAM	PMS
02238334	TEVA-CLOBAZAM	TEV

CLONAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

0.25MG TABLET

02442027	CLONAZEPAM	SIV
02179660	PMS-CLONAZEPAM	PMS

0.5MG TABLET

02177889	APO-CLONAZEPAM	APX
02230366	CLONAPAM	VAE
02442035	CLONAZEPAM	SIV
02270641	CO CLONAZEPAM	OBT
02130998	DOM-CLONAZEPAM	DPC
02224100	DOM-CLONAZEPAM-R	DPC
02230950	MYLAN-CLONAZEPAM	MYL
02048701	PMS-CLONAZEPAM	PMS
02207818	PMS-CLONAZEPAM-R	PMS
02311593	PRO-CLONAZEPAM	PDL
02242077	RIVA-CLONAZEPAM	RIV
00382825	RIVOTRIL	HLR
02233960	SANDOZ CLONAZEPAM	SDZ
02239024	TEVA-CLONAZEPAM	TEV

1MG TABLET

02230368	CLONAPAM	VAE
02442043	CLONAZEPAM	SIV
02270668	CO CLONAZEPAM	OBT
02048728	PMS-CLONAZEPAM	PMS
02311607	PRO-CLONAZEPAM	PDL
02233982	SANDOZ CLONAZEPAM	SDZ

2MG TABLET

02177897	APO-CLONAZEPAM	APX
02230369	CLONAPAM	VAE
02442051	CLONAZEPAM	SIV
02270676	CO CLONAZEPAM	OBT
02131013	DOM-CLONAZEPAM	DPC
02230951	MYLAN-CLONAZEPAM	MYL
02048736	PMS-CLONAZEPAM	PMS

28:12.08 ANTICONVULSANTS - BENZODIAZEPINES

CLONAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

2MG TABLET

02311615	PRO-CLONAZEPAM	PDL
02242078	RIVA-CLONAZEPAM	RIV
00382841	RIVOTRIL	HLR
02233985	SANDOZ CLONAZEPAM	SDZ
02239025	TEVA-CLONAZEPAM	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503020	BENZODIAZEPINE ORAL LIQUID	UNK

28:12.12 ANTICONVULSANTS - HYDANTOINS

PHENYTOIN

30MG CAPSULE

00022772	DILANTIN	PFI

100MG CAPSULE

02460912	APO-PHENYTOIN SODIUM	APX
00022780	DILANTIN	PFI

6MG/ML SUSPENSION

00023442	DILANTIN	PFI

25MG/ML SUSPENSION

00023450	DILANTIN	PFI
02250896	TARO-PHENYTOIN	TAR

50MG TABLET

00023698	DILANTIN INFATABS	PFI

28:12.20 ANTICONVULSANTS-SUCCINIMIDES

ETHOSUXIMIDE

250MG CAPSULE

00022799	ZARONTIN	ERF

50MG/ML SYRUP

00023485	ZARONTIN	ERF

28:12.92 MISCELLANEOUS ANTICONVULSANTS

CARBAMAZEPINE

20MG/ML SUSPENSION

02367394	TARO-CARBAMAZEPINE	TAR
02194333	TEGRETOL	NVR

200MG TABLET

00402699	APO CARBAMAZEPINE	APX
00504742	MAZEPINE	BMI
02407515	TARO-CARBAMAZEPINE	TAR
00010405	TEGRETOL	NVR
00782718	TEVA-CARBAMAZEPINE	TEV

28:12.92 MISCELLANEOUS ANTICONVULSANTS

CARBAMAZEPINE

100MG TABLET (CHEWABLE)

02231542	PMS-CARBAMAZEPINE	PMS
02244403	TARO-CARBAMAZEPINE	TAR

200MG TABLET (CHEWABLE)

02231540	PMS-CARBAMAZEPINE	PMS
02244404	TARO-CARBAMAZEPINE	TAR

200MG TABLET (EXTENDED RELEASE)

02413590	CARBAMAZEPINE	PDL
02238222	DOM-CARBAMAZEPINE	DPC
02231543	PMS-CARBAMAZEPINE	PMS
02261839	SANDOZ-CARBAMAZEPINE	SDZ
02237907	TARO-CARBAMAZEPINE	TAR
00773611	TEGRETOL	NVR

400MG TABLET (EXTENDED RELEASE)

02413604	CARBAMAZEPINE	PDL
02238223	DOM-CARBAMAZEPINE	DPC
02231544	PMS-CARBAMAZEPINE	PMS
02261847	SANDOZ-CARBAMAZEPINE	SDZ
02237908	TARO-CARBAMAZEPINE	TAR
00755583	TEGRETOL	NVR

ESLICARBAZEPINE ACETATE

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

200MG TABLET

02426862	APTIOM	SPC

400MG TABLET

02426870	APTIOM	SPC

600MG TABLET

02426889	APTIOM	SPC

800MG TABLET

02426897	APTIOM	SPC

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

100MG CAPSULE

02256142	ACT GABAPENTIN	ACG
02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC
02285819	GD-GABAPENTIN	PFI

28:12.92 MISCELLANEOUS ANTICONVULSANTS

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

100MG CAPSULE

02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02084260	NEURONTIN	PFI
02243446	PMS-GABAPENTIN	PMS
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBY
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV

300MG CAPSULE

02256150	ACT GABAPENTIN	ACG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC
02285827	GD-GABAPENTIN	PFI
02361485	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR
02084279	NEURONTIN	PFI
02243447	PMS-GABAPENTIN	PMS
02310457	PRO-GABAPENTIN	PDL
02319063	RAN-GABAPENTIN	RBY
02251175	RIVA-GABAPENTIN	RIV
02244514	TEVA-GABAPENTIN	TEV

400MG CAPSULE

02256169	ACT GABAPENTIN	ACG
02244306	APO-GABAPENTIN	APX
02321238	AURO-GABAPENTIN	AUR
02243745	DOM-GABAPENTIN	DPC
02246316	GABAPENTIN	SIV
02353261	GABAPENTIN	SAN
02416867	GABAPENTIN	ACC
02361493	JAMP-GABAPENTIN	JMP
02391503	MAR-GABAPENTIN	MAR
02248261	MYLAN-GABAPENTIN	MYL
02084287	NEURONTIN	PFI
02243448	PMS-GABAPENTIN	PMS
02310465	PRO-GABAPENTIN	PDL
02319071	RAN-GABAPENTIN	RBY
02251183	RIVA-GABAPENTIN	RIV
02244515	TEVA-GABAPENTIN	TEV

600MG TABLET

02293358	APO-GABAPENTIN	APX
02388200	GABAPENTIN	SIV
02392526	GABAPENTIN	ACC
02431289	GABAPENTIN	SAN

28:12.92 MISCELLANEOUS ANTICONVULSANTS

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

600MG TABLET

02285843	GD-GABAPENTIN	PFI
02402289	JAMP-GABAPENTIN	JMP
02239717	NEURONTIN	PFI
02255898	PMS-GABAPENTIN	PMS
02310473	PRO-GABAPENTIN	PDL
02259796	RIVA-GABAPENTIN	RIV
02248457	TEVA-GABAPENTIN	TEV

800MG TABLET

02293366	APO-GABAPENTIN	APX
02388219	GABAPENTIN	SIV
02392534	GABAPENTIN	ACC
02431297	GABAPENTIN	SAN
02402297	JAMP-GABAPENTIN	JMP
02239718	NEURONTIN	PFI
02255901	PMS-GABAPENTIN	PMS
02310481	PRO-GABAPENTIN	PDL
02259818	RIVA-GABAPENTIN	RIV
02247346	TEVA-GABAPENTIN	TEV

LACOSAMIDE

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

50MG TABLET

02357615	VIMPAT	UCB

100MG TABLET

02357623	VIMPAT	UCB

150MG TABLET

02357631	VIMPAT	UCB

200MG TABLET

02357658	VIMPAT	UCB

LAMOTRIGINE

2MG TABLET

02243803	LAMICTAL	GSK

5MG TABLET

02240115	LAMICTAL	GSK

25MG TABLET

02245208	APO-LAMOTRIGINE	APX
02381354	AURO-LAMOTRIGINE	AUR
02142082	LAMICTAL	GSK
02302969	LAMOTRIGINE	PDL
02343010	LAMOTRIGINE	SAN
02428202	LAMOTRIGINE	SIV
02265494	MYLAN-LAMOTRIGINE	MYL
02246897	PMS-LAMOTRIGINE	PMS
02248232	TEVA-LAMOTRIGINE	TEV

100MG TABLET

02245209	APO-LAMOTRIGINE	APX
02381362	AURO-LAMOTRIGINE	AUR
02142104	LAMICTAL	GSK
02302985	LAMOTRIGINE	PDL
02343029	LAMOTRIGINE	SAN
02428210	LAMOTRIGINE	SIV
02265508	MYLAN-LAMOTRIGINE	MYL
02246898	PMS-LAMOTRIGINE	PMS
02248233	TEVA-LAMOTRIGINE	TEV

150MG TABLET

02245210	APO-LAMOTRIGINE	APX
02381370	AURO-LAMOTRIGINE	AUR
02142112	LAMICTAL	GSK
02302993	LAMOTRIGINE	PDL
02343037	LAMOTRIGINE	SAN
02428229	LAMOTRIGINE	SIV
02265516	MYLAN-LAMOTRIGINE	MYL
02246899	PMS-LAMOTRIGINE	PMS
02248234	TEVA-LAMOTRIGINE	TEV

LEVETIRACETAM

250MG TABLET

02274183	ACT LEVETIRACETAM	ACG
02285924	APO-LEVETIRACETAM	APX
02375249	AURO-LEVETIRACETAM	AUR
02403005	JAMP-LEVETIRACETAM	JMP
02247027	KEPPRA	UCB
02353342	LEVETIRACETAM	SAN
02399776	LEVETIRACETAM	ACC
02442531	LEVETIRACETAM	SIV
02454653	LEVETIRACETAM	PMS
02440202	NAT-LEVETIRACETAM	NPH
02296101	PMS-LEVETIRACETAM	PMS
02396106	RAN-LEVETIRACETAM	RBY
02461986	SANDOZ LEVETIRACETAM	SDZ

500MG TABLET

02274191	ACT LEVETIRACETAM	ACG
02285932	APO-LEVETIRACETAM	APX
02375257	AURO-LEVETIRACETAM	AUR
02297418	DOM-LEVETIRACETAM	DPC
02403021	JAMP-LEVETIRACETAM	JMP
02247028	KEPPRA	UCB
02353350	LEVETIRACETAM	SAN
02399784	LEVETIRACETAM	ACC
02442558	LEVETIRACETAM	SIV
02454661	LEVETIRACETAM	PMS
02440210	NAT-LEVETIRACETAM	NPH
02296128	PMS-LEVETIRACETAM	PMS

28:12.92 MISCELLANEOUS ANTICONVULSANTS

LEVETIRACETAM

500MG TABLET

02311380	PRO-LEVETIRACETAM	PDL
02396114	RAN-LEVETIRACETAM	RBY
02461994	SANDOZ LEVETIRACETAM	SDZ

750MG TABLET

02274205	ACT LEVETIRACETAM	ACG
02285940	APO-LEVETIRACETAM	APX
02375265	AURO-LEVETIRACETAM	AUR
02403048	JAMP-LEVETIRACETAM	JMP
02247029	KEPPRA	UCB
02353369	LEVETIRACETAM	SAN
02399792	LEVETIRACETAM	ACC
02442566	LEVETIRACETAM	SIV
02454688	LEVETIRACETAM	PMS
02440229	NAT-LEVETIRACETAM	NPH
02296136	PMS-LEVETIRACETAM	PMS
02311399	PRO-LEVETIRACETAM	PDL
02396122	RAN-LEVETIRACETAM	RBY
02462001	SANDOZ LEVETIRACETAM	SDZ

PDIN FOR EXTEMPORANEOUS MIXTURE

99503026	LEVETIRACETAM ORAL LIQUID	UNK

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

25MG CAPSULE

02402912	ACT PREGABALIN	ACG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02382210	MYLAN-PREGABALIN	MYL
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02392801	RAN-PREGABALIN	RBY
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV

50MG CAPSULE

02402920	ACT PREGABALIN	ACG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

50MG CAPSULE

02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02382229	MYLAN-PREGABALIN	MYL
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02392828	RAN-PREGABALIN	RBY
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV

75MG CAPSULE

02402939	ACT PREGABALIN	ACG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02382237	MYLAN-PREGABALIN	MYL
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02392836	RAN-PREGABALIN	RBY
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV

150MG CAPSULE

02402955	ACT PREGABALIN	ACG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP
02268450	LYRICA	PFI
02417561	MAR-PREGABALIN	MAR
02424207	MINT-PREGABALIN	MIN
02382245	MYLAN-PREGABALIN	MYL
02359634	PMS-PREGABALIN	PMS
02396521	PREGABALIN	PDL

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

150MG CAPSULE

02403722	PREGABALIN	SIV
02405563	PREGABALIN	SAN
02392844	RAN-PREGABALIN	RBY
02377063	RIVA-PREGABALIN	RIV
02390841	SANDOZ PREGABALIN	SDZ
02361205	TEVA-PREGABALIN	TEV

300MG CAPSULE

02402998	ACT PREGABALIN	ACG
02394294	APO-PREGABALIN	APX
02436019	JAMP-PREGABALIN	JMP
02268485	LYRICA	PFI
02382253	MYLAN-PREGABALIN	MYL
02359642	PMS-PREGABALIN	PMS
02396548	PREGABALIN	PDL
02403730	PREGABALIN	SIV
02405598	PREGABALIN	SAN
02392860	RAN-PREGABALIN	RBY
02377071	RIVA-PREGABALIN	RIV
02390868	SANDOZ PREGABALIN	SDZ
02361248	TEVA-PREGABALIN	TEV

RUFINAMIDE

Limited use benefit (prior approval required).

- For the adjunctive treatment of seizures associated with Lennox-Gastaux syndrome in adults and children 4 years and older when prescribed by a neurologist or experienced specialist.
- Patient has failed or is intolerant to or has contraindications to at least two adjunctive antiepileptic drugs.

100MG TABLET

02369613	BANZEL	EIS

200MG TABLET

02369621	BANZEL	EIS

400MG TABLET

02369648	BANZEL	EIS

TOPIRAMATE

15MG CAPSULE

02239907	TOPAMAX	JSO

25MG CAPSULE

02239908	TOPAMAX	JSO

25MG TABLET

02351307	ACCEL-TOPIRAMATE	ACP
02287765	ACT TOPIRAMATE	ACG
02279614	APO-TOPIRAMATE	APX

28:12.92 MISCELLANEOUS ANTICONVULSANTS

TOPIRAMATE

25MG TABLET

02345803	AURO-TOPIRAMATE	APL
02271141	DOM-TOPIRAMATE	DPC
02435608	JAMP-TOPIRAMATE	JMP
02432099	MAR-TOPIRAMATE	MAR
02315645	MINT-TOPIRAMATE	MIN
02263351	MYLAN-TOPIRAMATE	MYL
02262991	PMS-TOPIRAMATE	PMS
02313650	PRO-TOPIRAMATE	PDL
02396076	RAN-TOPIRAMATE	RBY
02260050	SANDOZ TOPIRAMATE	SDZ
02431807	SANDOZ TOPIRAMATE	SDZ
02248860	TEVA-TOPIRAMATE	TEV
02230893	TOPAMAX	JSO
02356856	TOPIRAMATE	SAN
02389460	TOPIRAMATE	SIV
02395738	TOPIRAMATE	ACC

50MG TABLET

02312085	PMS-TOPIRAMATE	PMS

100MG TABLET

02351315	ACCEL-TOPIRAMATE	ACP
02287773	ACT TOPIRAMATE	ACG
02279630	APO-TOPIRAMATE	APX
02345838	AURO-TOPIRAMATE	APL
02271168	DOM-TOPIRAMATE	DPC
02435616	JAMP-TOPIRAMATE	JMP
02432102	MAR-TOPIRAMATE	MAR
02315653	MINT-TOPIRAMATE	MIN
02263378	MYLAN-TOPIRAMATE	MYL
02263009	PMS-TOPIRAMATE	PMS
02313669	PRO-TOPIRAMATE	PDL
02396084	RAN-TOPIRAMATE	RBY
02260069	SANDOZ TOPIRAMATE	SDZ
02431815	SANDOZ TOPIRAMATE	SDZ
02248861	TEVA-TOPIRAMATE	TEV
02230894	TOPAMAX	JSO
02356864	TOPIRAMATE	SAN
02389487	TOPIRAMATE	SIV
02395746	TOPIRAMATE	ACC

200MG TABLET

02351323	ACCEL-TOPIRAMATE	ACP
02287781	ACT TOPIRAMATE	ACG
02279649	APO-TOPIRAMATE	APX
02345846	AURO-TOPIRAMATE	APL
02271176	DOM-TOPIRAMATE	DPC
02435624	JAMP-TOPIRAMATE	JMP
02432110	MAR-TOPIRAMATE	MAR
02315661	MINT-TOPIRAMATE	MIN
02263386	MYLAN-TOPIRAMATE	MYL
02263017	PMS-TOPIRAMATE	PMS
02313677	PRO-TOPIRAMATE	PDL
02396092	RAN-TOPIRAMATE	RBY
02267837	SANDOZ TOPIRAMATE	SDZ
02431823	SANDOZ TOPIRAMATE	SDZ

28:12.92 MISCELLANEOUS ANTICONVULSANTS

TOPIRAMATE

200MG TABLET

02248862	TEVA-TOPIRAMATE	TEV
02230896	TOPAMAX	JSO
02356872	TOPIRAMATE	SAN
02395754	TOPIRAMATE	ACC

PDIN FOR EXTEMPORANEOUS MIXTURE

99503027	TOPIRAMATE ORAL LIQUID	UNK

VALPROIC ACID (DIVALPROEX SODIUM)

125MG TABLET (ENTERIC COATED)

02239698	APO-DIVALPROEX	APX
02400499	DIVALPROEX	SAN
00596418	EPIVAL	BGP
02458926	MYLAN-DIVALPROEX	MYL
02244138	PMS-DIVALPROEX	PMS
02239701	TEVA-DIVALPROEX	TEV

250MG TABLET (ENTERIC COATED)

02239699	APO-DIVALPROEX	APX
02400502	DIVALPROEX	SAN
00596426	EPIVAL	BGP
02458934	MYLAN-DIVALPROEX	MYL
02244139	PMS-DIVALPROEX	PMS
02239702	TEVA-DIVALPROEX	TEV

500MG TABLET (ENTERIC COATED)

02239700	APO-DIVALPROEX	APX
02400510	DIVALPROEX	SAN
00596434	EPIVAL	BGP
02459019	MYLAN-DIVALPROEX	MYL
02244140	PMS-DIVALPROEX	PMS
02239703	TEVA-DIVALPROEX	TEV

VALPROIC ACID (SODIUM VALPROATE)

250MG CAPSULE

02238048	APO-VALPROIC	APX
02231030	DOM-VALPROIC ACID	DPC
02100630	NOVO-VALPROIC	TEV
02230768	PMS-VALPROIC ACID	PMS
02239714	SANDOZ VALPROIC	SDZ

500MG CAPSULE (ENTERIC COATED)

02231031	DOM-VALPROIC ACID	DPC
02218321	NOVO-VALPROIC	TEV
02229628	PMS-VALPROIC ACID	PMS

50MG/ML SYRUP

02238370	APO-VALPROIC	APX
00443832	DEPAKENE	BGP
02238817	DOM-VALPROIC ACID	DPC
02236807	PMS-VALPROIC ACID	PMS

VIGABATRIN

500MG POWDER

02068036	SABRIL	LUK

500MG TABLET

02065819	SABRIL	LUK

28:16.04 ANTIDEPRESSANTS

AMITRIPTYLINE HYDROCHLORIDE

10MG TABLET

00370991	AMITRIPTYLINE	PDL
02403137	APO-AMITRIPTYLINE	APX
00335053	ELAVIL	AAP
02435527	JAMP-AMITRIPTYLINE	JMP
00293911	LEVATE	BMI
02429861	MAR-AMITRIPTYLINE	MAR
00654523	PMS-AMITRIPTYLINE	PMS
02326043	TEVA-AMITRIPTYLINE	TEV

25MG TABLET

00371009	AMITRIPTYLINE	PDL
02403145	APO-AMITRIPTYLINE	APX
00335061	ELAVIL	AAP
02435535	JAMP-AMITRIPTYLINE	JMP
02429888	MAR-AMITRIPTYLINE	MAR
00654515	PMS-AMITRIPTYLINE	PMS
02326051	TEVA-AMITRIPTYLINE	TEV

50MG TABLET

00456349	AMITRIPTYLINE	PDL
02403153	APO-AMITRIPTYLINE	APX
00335088	ELAVIL	AAP
02435543	JAMP-AMITRIPTYLINE	JMP
00271152	LEVATE	BMI
02429896	MAR-AMITRIPTYLINE	MAR
00654507	PMS-AMITRIPTYLINE	PMS
02326078	TEVA-AMITRIPTYLINE	TEV

75MG TABLET

02403161	APO-AMITRIPTYLINE	APX
00754129	ELAVIL	AAP
02435551	JAMP-AMITRIPTYLINE	JMP
00405612	LEVATE	BMI
02429918	MAR-AMITRIPTYLINE	MAR

BUPROPION HYDROCHLORIDE (WELLBUTRIN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

100MG TABLET (EXTENDED RELEASE)

02331616	BUPROPION SR	PDL
02391562	BUPROPION SR	SAN
02325373	PMS-BUPROPION SR	PMS
02285657	RATIO-BUPROPION	TEV
02275074	SANDOZ BUPROPION SR	SDZ

150MG TABLET (EXTENDED RELEASE)

02439654	ACT BUPROPION XL	ACG
02325357	BUPROPION SR	PDL
02391570	BUPROPION SR	SAN
02382075	MYLAN-BUPROPION XL	MYL
02313421	PMS-BUPROPION SR	PMS
02285665	RATIO-BUPROPION	TEV
02275082	SANDOZ BUPROPION SR	SDZ
02237825	WELLBUTRIN SR	VAE
02275090	WELLBUTRIN XL	VAE

28:16.04 ANTIDEPRESSANTS

BUPROPION HYDROCHLORIDE (WELLBUTRIN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

300MG TABLET (EXTENDED RELEASE)

02439662	ACT BUPROPION XL	ACG
02382083	MYLAN-BUPROPION XL	MYL
02275104	WELLBUTRIN XL	VAE

BUPROPION HYDROCHLORIDE (ZYBAN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

Coverage is limited to 180 tablets during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached the client is eligible again for coverage for bupropion hydrochloride when one year has elapsed from the day the initial prescription was filled.

150MG TABLET (EXTENDED RELEASE)

02238441	ZYBAN	VAE

CITALOPRAM HYDROBROMIDE

10MG TABLET

02355248	ACCEL-CITALOPRAM	ACP
02325047	CITALOPRAM	PDL
02387948	CITALOPRAM	SIV
02430517	CITALOPRAM	JMP
02445719	CITALOPRAM	SAN
02273055	DOM-CITALOPRAM	DPC
02421739	ECL-CITALOPRAM	ECL
02370085	JAMP-CITALOPRAM	JMP
02371871	MAR-CITALOPRAM	MAR
02370077	MINT-CITALOPRAM	MIN
02429691	MINT-CITALOPRAM	MIN
02409003	NAT-CITALOPRAM	NPH
02270609	PMS-CITALOPRAM	PMS
02303256	RIVA-CITALOPRAM	RIV
02431629	SEPTA-CITALOPRAM	SPT
02312336	TEVA-CITALOPRAM	TEV

20MG TABLET

02355256	ACCEL-CITALOPRAM	ACP
02248050	ACT CITALOPRAM	ACG
02246056	APO-CITALOPRAM	APX
02275562	AURO-CITALOPRAM	AUR
02239607	CELEXA	LUD
02257513	CITALOPRAM	PDL
02353660	CITALOPRAM	SAN
02387956	CITALOPRAM	SIV
02430541	CITALOPRAM	JMP
02248942	DOM-CITALOPRAM	DPC
02313405	JAMP-CITALOPRAM	JMP
02371898	MAR-CITALOPRAM	MAR
02304686	MINT-CITALOPRAM	MIN
02429705	MINT-CITALOPRAM	MIN
02246594	MYLAN-CITALOPRAM	MYL

28:16.04 ANTIDEPRESSANTS

CITALOPRAM HYDROBROMIDE

20MG TABLET

02409011	NAT-CITALOPRAM	NPH
02248010	PMS-CITALOPRAM	PMS
02285622	RAN-CITALO	RBY
02303264	RIVA-CITALOPRAM	RIV
02248170	SANDOZ CITALOPRAM	SDZ
02355272	SEPTA-CITALOPRAM	SPT
02293218	TEVA-CITALOPRAM	TEV

30MG TABLET

02296152	CTP 30	SPC

40MG TABLET

02355264	ACCEL-CITALOPRAM	ACP
02248051	ACT CITALOPRAM	ACG
02246057	APO-CITALOPRAM	APX
02275570	AURO-CITALOPRAM	AUR
02239608	CELEXA	LUD
02257521	CITALOPRAM	PDL
02353679	CITALOPRAM	SAN
02387964	CITALOPRAM	SIV
02430568	CITALOPRAM	JMP
02248943	DOM-CITALOPRAM	DPC
02313413	JAMP-CITALOPRAM	JMP
02371901	MAR-CITALOPRAM	MAR
02304694	MINT-CITALOPRAM	MIN
02429713	MINT-CITALOPRAM	MIN
02246595	MYLAN-CITALOPRAM	MYL
02409038	NAT-CITALOPRAM	NPH
02248011	PMS-CITALOPRAM	PMS
02285630	RAN-CITALO	RBY
02303272	RIVA-CITALOPRAM	RIV
02248171	SANDOZ CITALOPRAM	SDZ
02355280	SEPTA-CITALOPRAM	SPT
02293226	TEVA-CITALOPRAM	TEV

CLOMIPRAMINE HYDROCHLORIDE

10MG TABLET

00330566	ANAFRANIL	AAP

25MG TABLET

00324019	ANAFRANIL	AAP

50MG TABLET

00402591	ANAFRANIL	AAP

DESIPRAMINE HYDROCHLORIDE

10MG TABLET

02216248	DESIPRAMINE	AAP
02223341	NOVO-DESIPRAMINE	NOP

25MG TABLET

02216256	DESIPRAMINE	AAP
02223325	NOVO-DESIPRAMINE	NOP

50MG TABLET

02216264	DESIPRAMINE	AAP
02223333	NOVO-DESIPRAMINE	NOP
01946277	PMS DESIPRAMINE	PMS

75MG TABLET

02216272	DESIPRAMINE	AAP
02223368	NOVO-DESIPRAMINE	NOP

28:16.04 ANTIDEPRESSANTS

DESIPRAMINE HYDROCHLORIDE

75MG TABLET

01946242	PMS DESIPRAMINE	PMS

100MG TABLET

02216280	DESIPRAMINE	AAP

DOXEPIN HYDROCHLORIDE

10MG CAPSULE

02049996	APO-DOXEPIN	APX
00024325	SINEQUAN	AAP

25MG CAPSULE

02050005	APO-DOXEPIN	APX
00024333	SINEQUAN	AAP

50MG CAPSULE

02050013	APO-DOXEPIN	APX
00024341	SINEQUAN	AAP

75MG CAPSULE

02050021	APO-DOXEPIN	APX
00400750	SINEQUAN	AAP

100MG CAPSULE

02050048	APO-DOXEPIN	APX
00326925	SINEQUAN	AAP

150MG CAPSULE

02050056	APO-DOXEPIN	APX

DULOXETINE HYDROCHLORIDE

30MG CAPSULE (DELAYED RELEASE)

02440423	APO-DULOXETINE	APX
02436647	AURO-DULOXETINE	AUR
02301482	CYMBALTA	LIL
02452650	DULOXETINE	PDL
02453630	DULOXETINE	SIV
02437082	DULOXETINE DR	TEV
02451913	JAMP-DULOXETINE	JMP
02446081	MAR-DULOXETINE	MAR
02438984	MINT-DULOXETINE	MIN
02426633	MYLAN-DULOXETINE	MYL
02429446	PMS-DULOXETINE	PMS
02438259	RAN-DULOXETINE	RBY
02451077	RIVA-DULOXETINE	RIV
02439948	SANDOZ DULOXETINE	SDZ

60MG CAPSULE (DELAYED RELEASE)

02440431	APO-DULOXETINE	APX
02436655	AURO-DULOXETINE	AUR
02301490	CYMBALTA	LIL
02452669	DULOXETINE	PDL
02453649	DULOXETINE	SIV
02437090	DULOXETINE DR	TEV
02451921	JAMP-DULOXETINE	JMP
02446103	MAR-DULOXETINE	MAR
02438992	MINT-DULOXETINE	MIN
02426641	MYLAN-DULOXETINE	MYL
02429454	PMS-DULOXETINE	PMS
02438267	RAN-DULOXETINE	RBY
02451085	RIVA-DULOXETINE	RIV
02439956	SANDOZ DULOXETINE	SDZ

28:16.04 ANTIDEPRESSANTS

ESCITALOPRAM OXALATE

10MG TABLET

02434652	ACH-ESCITALOPRAM	ACC
02313561	ACT ESCITALOPRAM	ACG
02295016	APO-ESCITALOPRAM	APX
02397358	AURO-ESCITALOPRAM	AUR
02263238	CIPRALEX	LUD
02424401	ESCITALOPRAM	PDL
02429039	ESCITALOPRAM	SIV
02430118	ESCITALOPRAM	SAN
02429780	JAMP-ESCITALOPRAM	JMP
02423480	MAR-ESCITALOPRAM	MAR
02407418	MINT-ESCITALOPRAM	MIN
02309467	MYLAN-ESCITALOPRAM	MYL
02440296	NAT-ESCITALOPRAM	NPH
02303949	PMS-ESCITALOPRAM	PMS
02426331	PRIVA-ESCITALOPRAM	PHA
02385481	RAN-ESCITALOPRAM	RBY
02428830	RIVA-ESCITALOPRAM	RIV
02364077	SANDOZ ESCITALOPRAM	SDZ
02318180	TEVA-ESCITALOPRAM	TEV

20MG TABLET

02434660	ACH-ESCITALOPRAM	ACC
02313588	ACT ESCITALOPRAM	ACG
02295024	APO-ESCITALOPRAM	APX
02397374	AURO-ESCITALOPRAM	AUR
02263254	CIPRALEX	LUD
02424428	ESCITALOPRAM	PDL
02429047	ESCITALOPRAM	SIV
02430126	ESCITALOPRAM	SAN
02429799	JAMP-ESCITALOPRAM	JMP
02423502	MAR-ESCITALOPRAM	MAR
02407434	MINT-ESCITALOPRAM	MIN
02309475	MYLAN-ESCITALOPRAM	MYL
02440318	NAT-ESCITALOPRAM	NPH
02303965	PMS-ESCITALOPRAM	PMS
02426358	PRIVA-ESCITALOPRAM	PHA
02385503	RAN-ESCITALOPRAM	RBY
02428857	RIVA-ESCITALOPRAM	RIV
02364085	SANDOZ ESCITALOPRAM	SDZ
02318202	TEVA-ESCITALOPRAM	TEV

10MG TABLET (ORALLY DISINTEGRATING)

02454297	ACT ESCITALOPRAM ODT	ACG
02391449	CIPRALEX MELTZ	LUD

20MG TABLET (ORALLY DISINTEGRATING)

02454300	ACT ESCITALOPRAM ODT	ACG
02391457	CIPRALEX MELTZ	LUD

FLUOXETINE HYDROCHLORIDE

10MG CAPSULE

02400391	ACCEL-FLUOXETINE	ACP
02393441	ACH-FLUOXETINE	ACC
02242177	ACT FLUOXETINE	REC
02216353	APO-FLUOXETINE	APX
02385627	AURO-FLUOXETINE	AUR
02448424	BIO-FLUOXETINE	BMI
02177617	DOM-FLUOXETINE	DPC

28:16.04 ANTIDEPRESSANTS

FLUOXETINE HYDROCHLORIDE

10MG CAPSULE

02286068	FLUOXETINE	SAN
02374447	FLUOXETINE	SIV
02401894	JAMP-FLUOXETINE	JMP
02392909	MAR-FLUOXETINE	MAR
02380560	MINT-FLUOXETINE	MIN
02237813	MYLAN-FLUOXETINE	MYL
02177579	PMS-FLUOXETINE	PMS
02314991	PRO-FLUOXETINE	PDL
02018985	PROZAC	LIL
02405695	RAN-FLUOXETINE	RBY
02216582	TEVA-FLUOXETINE	TEV
02432412	VAN-FLUOXETINE	VAN

20MG CAPSULE

02400405	ACCEL-FLUOXETINE	ACP
02383241	ACH-FLUOXETINE	ACC
02242178	ACT FLUOXETINE	REC
02216361	APO-FLUOXETINE	APX
02385635	AURO-FLUOXETINE	AUR
02448432	BIO-FLUOXETINE	BMI
02177625	DOM-FLUOXETINE	DPC
02286076	FLUOXETINE	SAN
02374455	FLUOXETINE	SIV
02386402	JAMP-FLUOXETINE	JMP
02392917	MAR-FLUOXETINE	MAR
02380579	MINT-FLUOXETINE	MIN
02237814	MYLAN-FLUOXETINE	MYL
02177587	PMS-FLUOXETINE	PMS
02315009	PRO-FLUOXETINE	PDL
00636622	PROZAC	LIL
02405709	RAN-FLUOXETINE	RBY
02305488	RIVA-FLUOXETINE	RIV
02216590	TEVA-FLUOXETINE	TEV
02432420	VAN-FLUOXETINE	VAN

4MG/ML SOLUTION

02231328	APO-FLUOXETINE	APX

20MG SOLUTION

02459361	ODAN-FLUOXETINE	ODN

FLUVOXAMINE MALEATE

50MG TABLET

02255529	ACT FLUVOXAMINE	ACG
02231329	APO-FLUVOXAMINE	APX
02236753	FLUVOXAMINE	PDL
01919342	LUVOX	BGP
02239953	NOVO-FLUVOXAMINE	TEV
02218453	RATIO-FLUVOXAMINE	TEV
02303345	RIVA-FLUVOX	RIV
02247054	SANDOZ FLUVOXAMINE	SDZ

100MG TABLET

02255537	ACT FLUVOXAMINE	ACG
02231330	APO-FLUVOXAMINE	APX
02236754	FLUVOXAMINE	PDL
01919369	LUVOX	BGP
02239954	NOVO-FLUVOXAMINE	TEV
02218461	RATIO-FLUVOXAMINE	TEV
02303361	RIVA-FLUVOX	RIV
02247055	SANDOZ FLUVOXAMINE	SDZ

28:16.04 ANTIDEPRESSANTS

FLUVOXAMINE MALEATE

IMIPRAMINE HYDROCHLORIDE

10MG TABLET

00360201	IMIPRAMINE	AAP
00021504	NOVO-PRAMINE	NOP

25MG TABLET

00312797	IMIPRAMINE	AAP

50MG TABLET

00326852	IMIPRAMINE	AAP
00021520	NOVO-PRAMINE	NOP

75MG TABLET

00644579	IMIPRAMINE	AAP

MAPROTILINE HYDROCHLORIDE

25MG TABLET

02158612	TEVA-MAPROTILINE	TEV

50MG TABLET

02158620	TEVA-MAPROTILINE	TEV

75MG TABLET

02158639	TEVA-MAPROTILINE	TEV

MIRTAZAPINE

15MG TABLET

02286610	APO-MIRTAZAPINE	APX
02411695	AURO-MIRTAZAPINE	AUR
02256096	MYLAN-MIRTAZAPINE	MYL
02273942	PMS-MIRTAZAPINE	PMS
02312778	PRO-MIRTAZAPINE	PDL
02250594	SANDOZ MIRTAZAPINE	SDZ

30MG TABLET

02286629	APO-MIRTAZAPINE	APX
02411709	AURO-MIRTAZAPINE	AUR
02252287	DOM-MIRTAZAPINE	DPC
02370689	MIRTAZAPINE	SAN
02256118	MYLAN-MIRTAZAPINE	MYL
02248762	PMS-MIRTAZAPINE	PMS
02312786	PRO-MIRTAZAPINE	PDL
02243910	REMERON	FRS
02265265	RIVA-MIRTAZAPINE	RIV
02250608	SANDOZ MIRTAZAPINE	SDZ
02259354	TEVA-MIRTAZAPINE	TEV

45MG TABLET

02286637	APO-MIRTAZAPINE	APX
02411717	AURO-MIRTAZAPINE	AUR
02256126	MYLAN-MIRTAZAPINE	MYL

15MG TABLET (ORALLY DISINTEGRATING)

02299801	AURO-MIRTAZAPINE OD	AUR
02248542	REMERON RD	FRS
02279894	TEVA-MIRTAZAPINE OD	TEV

30MG TABLET (ORALLY DISINTEGRATING)

02299828	AURO-MIRTAZAPINE OD	AUR
02248543	REMERON RD	FRS
02279908	TEVA-MIRTAZAPINE OD	TEV

28:16.04 ANTIDEPRESSANTS

MIRTAZAPINE

45MG TABLET (ORALLY DISINTEGRATING)

02299836	AURO-MIRTAZAPINE OD	AUR
02248544	REMERON RD	FRS
02279916	TEVA-MIRTAZAPINE OD	TEV

MOCLOBEMIDE

100MG TABLET

02232148	MOCLOBEMIDE	AAP
02239746	TEVA-MOCLOBEMIDE	TEV

150MG TABLET

00899356	MANERIX	VAE
02232150	MOCLOBEMIDE	AAP
02243218	PMS-MOCLOBEMIDE	PMS
02239747	TEVA-MOCLOBEMIDE	TEV

300MG TABLET

02166747	MANERIX	VAE
02240456	MOCLOBEMIDE	AAP
02243219	PMS-MOCLOBEMIDE	PMS
02239748	TEVA-MOCLOBEMIDE	TEV

NORTRIPTYLINE HYDROCHLORIDE

10MG CAPSULE

02223511	APO-NORTRIPTYLINE	APX
00015229	AVENTYL	AAP

25MG CAPSULE

02223538	APO-NORTRIPTYLINE	APX
00015237	AVENTYL	AAP

PAROXETINE HYDROCHLORIDE

10MG TABLET

02262746	ACT PAROXETINE	ACG
02240907	APO-PAROXETINE	APX
02383276	AURO-PAROXETINE	AUR
02248447	DOM-PAROXETINE	DPC
02368862	JAMP-PAROXETINE	JMP
02411946	MAR-PAROXETINE	MAR
02421372	MINT-PAROXETINE	MIN
02248012	MYLAN-PAROXETINE	MYL
02248913	PAROXETINE	PDL
02282844	PAROXETINE	SAN
02388227	PAROXETINE	SIV
02027887	PAXIL	GSK
02247750	PMS-PAROXETINE	PMS
02248559	RIVA-PAROXETINE	RIV
02269422	SANDOZ PAROXETINE	SDZ
02431777	SANDOZ PAROXETINE	SDZ
02248556	TEVA-PAROXETINE	TEV

20MG TABLET

02262754	ACT PAROXETINE	ACG
02240908	APO-PAROXETINE	APX
02383284	AURO-PAROXETINE	AUR
02248448	DOM-PAROXETINE	DPC
02368870	JAMP-PAROXETINE	JMP
02411954	MAR-PAROXETINE	MAR
02421380	MINT-PAROXETINE	MIN
02248013	MYLAN-PAROXETINE	MYL

28:16.04 ANTIDEPRESSANTS

PAROXETINE HYDROCHLORIDE

20MG TABLET

02248914	PAROXETINE	PDL
02282852	PAROXETINE	SAN
02388235	PAROXETINE	SIV
01940481	PAXIL	GSK
02247751	PMS-PAROXETINE	PMS
02248560	RIVA-PAROXETINE	RIV
02269430	SANDOZ PAROXETINE	SDZ
02431785	SANDOZ PAROXETINE	SDZ
02248557	TEVA-PAROXETINE	TEV

30MG TABLET

02262762	ACT PAROXETINE	ACG
02240909	APO-PAROXETINE	APX
02383292	AURO-PAROXETINE	AUR
02248449	DOM-PAROXETINE	DPC
02368889	JAMP-PAROXETINE	JMP
02411962	MAR-PAROXETINE	MAR
02421399	MINT-PAROXETINE	MIN
02248014	MYLAN-PAROXETINE	MYL
02248915	PAROXETINE	PDL
02282860	PAROXETINE	SAN
02388243	PAROXETINE	SIV
01940473	PAXIL	GSK
02247752	PMS-PAROXETINE	PMS
02248561	RIVA-PAROXETINE	RIV
02269449	SANDOZ PAROXETINE	SDZ
02431793	SANDOZ PAROXETINE	SDZ
02248558	TEVA-PAROXETINE	TEV

40MG TABLET

02293749	PMS-PAROXETINE	PMS

PHENELZINE SULFATE

15MG TABLET

00476552	NARDIL	ERF

SERTRALINE HYDROCHLORIDE

25MG CAPSULE

02287390	ACT SERTRALINE	ACG
02238280	APO-SERTRALINE	APX
02390906	AURO-SERTRALINE	AUR
02245748	DOM-SERTRALINE	DPC
02357143	JAMP-SERTRALINE	JMP
02399415	MAR-SERTRALINE	MAR
02402378	MINT-SERTRALINE	MIN
02242519	MYLAN-SERTRALINE	MYL
02244838	PMS-SERTRALINE	PMS
02374552	RAN-SERTRALINE	RBY
02248496	RIVA-SERTRALINE	RIV
02245159	SANDOZ SERTRALINE	SDZ
02353520	SERTRALINE	SAN
02386070	SERTRALINE	SIV
02241302	SERTRALINE-25	PDL
02240485	TEVA-SERTRALINE	TEV
02132702	ZOLOFT	PFI

50MG CAPSULE

02287404	ACT SERTRALINE	ACG

28:16.04 ANTIDEPRESSANTS

SERTRALINE HYDROCHLORIDE

50MG CAPSULE

02238281	APO-SERTRALINE	APX
02390914	AURO-SERTRALINE	AUR
02245749	DOM-SERTRALINE	DPC
02357151	JAMP-SERTRALINE	JMP
02399423	MAR-SERTRALINE	MAR
02402394	MINT-SERTRALINE	MIN
02242520	MYLAN-SERTRALINE	MYL
02244839	PMS-SERTRALINE	PMS
02374560	RAN-SERTRALINE	RBY
02248497	RIVA-SERTRALINE	RIV
02245160	SANDOZ SERTRALINE	SDZ
02353539	SERTRALINE	SAN
02386089	SERTRALINE	SIV
02241303	SERTRALINE-50	PDL
02240484	TEVA-SERTRALINE	TEV
01962817	ZOLOFT	PFI

100MG CAPSULE

02287412	ACT SERTRALINE	ACG
02238282	APO-SERTRALINE	APX
02390922	AURO-SERTRALINE	AUR
02245750	DOM-SERTRALINE	DPC
02357178	JAMP-SERTRALINE	JMP
02399431	MAR-SERTRALINE	MAR
02402408	MINT-SERTRALINE	MIN
02242521	MYLAN-SERTRALINE	MYL
02244840	PMS-SERTRALINE	PMS
02374579	RAN-SERTRALINE	RBY
02248498	RIVA-SERTRALINE	RIV
02245161	SANDOZ SERTRALINE	SDZ
02353547	SERTRALINE	SAN
02386097	SERTRALINE	SIV
02241304	SERTRALINE-100	PDL
02240481	TEVA-SERTRALINE	TEV
01962779	ZOLOFT	PFI

TRANYLCYPROMINE SULFATE

10MG TABLET

01919598	PARNATE	GSK

TRAZODONE HYDROCHLORIDE

50MG TABLET

02147637	APO-TRAZODONE	APX
02128950	DOM-TRAZODONE	DPC
01937227	PMS TRAZODONE	PMS
02277344	RATIO-TRAZODONE	TEV
02144263	TEVA-TRAZODONE	TEV
02164353	TRAZODONE	PDL
02348772	TRAZODONE	SAN

75MG TABLET

02237339	PMS-TRAZODONE	PMS

100MG TABLET

02147645	APO-TRAZODONE	APX
02128969	DOM-TRAZODONE	DPC
01937235	PMS TRAZODONE	PMS
02277352	RATIO-TRAZODONE	TEV

28:16.04 ANTIDEPRESSANTS

TRAZODONE HYDROCHLORIDE

100MG TABLET

02144271	TEVA-TRAZODONE	TEV
02164361	TRAZODONE	PDL
02348780	TRAZODONE	SAN

150MG TABLET

02147653	APO-TRAZODONE D	APX
02277360	RATIO-TRAZODONE	TEV
02144298	TEVA-TRAZODONE	TEV
02164388	TRAZODONE	PDL
02348799	TRAZODONE	SAN

TRIMIPRAMINE MALEATE

75MG CAPSULE

02070987	TRIMIPRAMINE	AAP

12.5MG TABLET

00740799	TRIMIPRAMINE	AAP

25MG TABLET

00740802	TRIMIPRAMINE	AAP

50MG TABLET

00740810	TRIMIPRAMINE	AAP

100MG TABLET

00740829	TRIMIPRAMINE	AAP

VENLAFAXINE HYDROCHLORIDE

37.5MG CAPSULE (EXTENDED RELEASE)

02304317	ACT VENLAFAXINE XR	ACG
02331683	APO-VENLAFAXINE XR	APX
02452839	AURO-VENLAFAXINE XR	AUR
02299291	DOM-VENLAFAXINE XR	DPC
02237279	EFFEXOR XR	PFI
02360020	GD-VENLAFAXINE XR	PFI
02310279	MYLAN-VENLAFAXINE XR	MYL
02278545	PMS-VENLAFAXINE XR	PMS
02380072	RAN-VENLAFAXINE XR	RBY
02307774	RIVA-VENLAFAXINE XR	RIV
02310317	SANDOZ VENLAFAXINE XR	SDZ
02275023	TEVA-VENLAFAXINE XR	TEV
02339242	VENLAFAXINE XR	PDL
02354713	VENLAFAXINE XR	SAN
02385929	VENLAFAXINE XR	SIV

75MG CAPSULE (EXTENDED RELEASE)

02304325	ACT VENLAFAXINE XR	ACG
02331691	APO-VENLAFAXINE XR	APX
02452847	AURO-VENLAFAXINE XR	AUR
02299305	DOM-VENLAFAXINE XR	DPC
02237280	EFFEXOR XR	PFI
02360039	GD-VENLAFAXINE XR	PFI
02310287	MYLAN-VENLAFAXINE XR	MYL
02278553	PMS-VENLAFAXINE XR	PMS
02380080	RAN-VENLAFAXINE XR	RBY
02307782	RIVA-VENLAFAXINE XR	RIV
02310325	SANDOZ VENLAFAXINE XR	SDZ
02275031	TEVA-VENLAFAXINE XR	TEV
02339250	VENLAFAXINE XR	PDL
02354721	VENLAFAXINE XR	SAN
02385937	VENLAFAXINE XR	SIV

28:16.04 ANTIDEPRESSANTS

VENLAFAXINE HYDROCHLORIDE

150MG CAPSULE (EXTENDED RELEASE)

02304333	ACT VENLAFAXINE XR	ACG
02331705	APO-VENLAFAXINE XR	APX
02452855	AURO-VENLAFAXINE XR	AUR
02299313	DOM-VENLAFAXINE XR	DPC
02237282	EFFEXOR XR	PFI
02360047	GD-VENLAFAXINE XR	PFI
02310295	MYLAN-VENLAFAXINE XR	MYL
02278561	PMS-VENLAFAXINE XR	PMS
02380099	RAN-VENLAFAXINE XR	RBY
02307790	RIVA-VENLAFAXINE XR	RIV
02310333	SANDOZ VENLAFAXINE XR	SDZ
02275058	TEVA-VENLAFAXINE XR	TEV
02339269	VENLAFAXINE XR	PDL
02354748	VENLAFAXINE XR	SAN
02385945	VENLAFAXINE XR	SIV

28:16.08 ANTIPSYCHOTIC AGENTS

ARIPIPRAZOLE

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:
- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

2MG TABLET

02322374	ABILIFY	OTS

5MG TABLET

02322382	ABILIFY	OTS

10MG TABLET

02322390	ABILIFY	OTS

15MG TABLET

02322404	ABILIFY	OTS

20MG TABLET

02322412	ABILIFY	OTS

30MG TABLET

02322455	ABILIFY	OTS

ARIPIPRAZOLE (MAINTENA)

300MG INJECTION

02420864	ABILIFY MAINTENA	OTS

400MG INJECTION

02420872	ABILIFY MAINTENA	OTS

ASENAPINE MALEATE

Limited use benefit (prior approval required).

For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either:
- Monotherapy, after a trial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of response; OR
- Co-therapy with lithium or divalproex sodium, after trials of two atypical antipsychotic agents have failed due to intolerance or lack of response.

5MG TABLET

02374803	SAPHRIS	FRS

28:16.08 ANTIPSYCHOTIC AGENTS

ASENAPINE MALEATE

Limited use benefit (prior approval required).

For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either:
- Monotherapy, after a trial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of response; OR
- Co-therapy with lithium or divalproex sodium, after trials of two atypical antipsychotic agents have failed due to intolerance or lack of response.

10MG TABLET

02374811	SAPHRIS	FRS

CHLORPROMAZINE HYDROCHLORIDE

25MG/ML LIQUID

00743518	CHLORPROMAZINE	SDZ

25MG TABLET

00232823	TEVA-CHLORPROMAZINE	TEV

50MG TABLET

00232807	TEVA-CHLORPROMAZINE	TEV

100MG TABLET

00232831	TEVA-CHLORPROMAZINE	TEV

CLOZAPINE

25MG TABLET

02248034	AA-CLOZAPINE	AAP
00894737	CLOZARIL	HLS
02247243	GEN-CLOZAPINE	MYL

50MG TABLET

02305003	GEN-CLOZAPINE	MYL

100MG TABLET

02248035	AA-CLOZAPINE	AAP
00894745	CLOZARIL	HLS
02247244	GEN-CLOZAPINE	MYL

200MG TABLET

02305011	GEN-CLOZAPINE	MYL

FLUPENTHIXOL DIHYDROCHLORIDE

0.5MG TABLET

02156008	FLUANXOL	LUD

3MG TABLET

02156016	FLUANXOL	LUD

FLUPENTIXOL DECANOATE

20MG/ML SOLUTION

02156032	FLUANXOL DEPOT	LUD

100MG/ML SOLUTION

02156040	FLUANXOL DEPOT	LUD

FLUPHENAZINE DECANOATE

25MG/ML LIQUID

02091275	PMS-FLUPHENAZINE	PMS

100MG/ML LIQUID

00755575	MODECATE	BMS
02241928	PMS-FLUPHENAZINE	PMS

FLUPHENAZINE HYDROCHLORIDE

1MG TABLET

00405345	FLUPHENAZINE	AAP

28:16.08 ANTIPSYCHOTIC AGENTS

FLUPHENAZINE HYDROCHLORIDE

2MG TABLET

00410632	FLUPHENAZINE	AAP

5MG TABLET

00405361	FLUPHENAZINE	AAP
00726354	PMS FLUPHENAZINE	PMS

HALOPERIDOL

2MG/ML SOLUTION

00759503	PMS-HALOPERIDOL	PMS

5MG/ML SOLUTION

00808652	HALOPERIDOL	SDZ
02366010	HALOPERIDOL	OMG

0.5MG TABLET

00396796	APO HALOPERIDOL	APX
00363685	TEVA-HALOPERIDOL	TEV

1MG TABLET

00396818	APO HALOPERIDOL	APX
00363677	TEVA-HALOPERIDOL	TEV

2MG TABLET

00363669	TEVA-HALOPERIDOL	TEV

5MG TABLET

00363650	TEVA-HALOPERIDOL	TEV

10MG TABLET

00463698	APO-HALOPERIDOL	APX
00713449	TEVA-HALOPERIDOL	TEV

20MG TABLET

00768820	TEVA-HALOPERIDOL	TEV

HALOPERIDOL DECANOATE

50MG/ML LIQUID

02130297	HALOPERIDOL LA	SDZ
02230707	PMS-HALOPERIDOL	PMS

100MG/ML LIQUID

02130300	HALOPERIDOL LA	SDZ
02239640	HALOPERIDOL LA	OMG
02230708	PMS-HALOPERIDOL	PMS

LOXAPINE HYDROCHLORIDE

25MG/ML SOLUTION

02239101	XYLAC	PED

LOXAPINE SUCCINATE

2.5MG TABLET

02242868	XYLAC	PED

5MG TABLET

02239918	DOM-LOXAPINE	DPC
02230837	XYLAC	PED

10MG TABLET

02239919	DOM-LOXAPINE	DPC
02230838	XYLAC	PED

25MG TABLET

02239920	DOM-LOXAPINE	DPC
02230839	XYLAC	PED

50MG TABLET

02239921	DOM-LOXAPINE	DPC
02230840	XYLAC	PED

28:16.08 ANTIPSYCHOTIC AGENTS

LURASIDONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders, in patients:

- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

20MG TABLET

02422050	LATUDA	SPC

40MG TABLET

02387751	LATUDA	SPC

60MG TABLET

02413361	LATUDA	SPC

80MG TABLET

02387778	LATUDA	SPC

120MG TABLET

02387786	LATUDA	SPC

METHOTRIMEPRAZINE MALEATE

2MG TABLET

02238403	METHOPRAZINE	AAP

5MG TABLET

02238404	METHOPRAZINE	AAP

25MG TABLET

02238405	METHOPRAZINE	AAP
01964925	NOVO-MEPRAZINE	NOP

50MG TABLET

02238406	METHOPRAZINE	AAP

OLANZAPINE

2.5MG TABLET

02325659	ACT OLANZAPINE	ACG
02281791	APO-OLANZAPINE	APX
02417243	JAMP-OLANZAPINE	JMP
02421232	MAR-OLANZAPINE	MAR
02337878	MYLAN-OLANZAPINE	MYL
02311968	OLANZAPINE	PDL
02372819	OLANZAPINE	SAN
02385864	OLANZAPINE	SIV
02303116	PMS-OLANZAPINE	PMS
02403064	RAN-OLANZAPINE	RBY
02337126	RIVA-OLANZAPINE	RIV
02310341	SANDOZ OLANZAPINE	SDZ
02276712	TEVA-OLANZAPINE	TEV
02229250	ZYPREXA	LIL

5MG TABLET

02325667	ACT OLANZAPINE	ACG
02281805	APO-OLANZAPINE	APX
02417251	JAMP-OLANZAPINE	JMP
02421240	MAR-OLANZAPINE	MAR
02337886	MYLAN-OLANZAPINE	MYL
02311976	OLANZAPINE	PDL
02372827	OLANZAPINE	SAN
02385872	OLANZAPINE	SIV
02303159	PMS-OLANZAPINE	PMS
02403072	RAN-OLANZAPINE	RBY
02337134	RIVA-OLANZAPINE	RIV

28:16.08 ANTIPSYCHOTIC AGENTS

OLANZAPINE

5MG TABLET

02310368	SANDOZ OLANZAPINE	SDZ
02276720	TEVA-OLANZAPINE	TEV
02229269	ZYPREXA	LIL

7.5MG TABLET

02325675	ACT OLANZAPINE	ACG
02281813	APO-OLANZAPINE	APX
02417278	JAMP-OLANZAPINE	JMP
02421259	MAR-OLANZAPINE	MAR
02337894	MYLAN-OLANZAPINE	MYL
02311984	OLANZAPINE	PDL
02372835	OLANZAPINE	SAN
02385880	OLANZAPINE	SIV
02303167	PMS-OLANZAPINE	PMS
02403080	RAN-OLANZAPINE	RBY
02337142	RIVA-OLANZAPINE	RIV
02310376	SANDOZ OLANZAPINE	SDZ
02276739	TEVA-OLANZAPINE	TEV
02229277	ZYPREXA	LIL

10MG TABLET

02325683	ACT OLANZAPINE	ACG
02281821	APO-OLANZAPINE	APX
02417286	JAMP-OLANZAPINE	JMP
02421267	MAR-OLANZAPINE	MAR
02337908	MYLAN-OLANZAPINE	MYL
02311992	OLANZAPINE	PDL
02372843	OLANZAPINE	SAN
02385899	OLANZAPINE	SIV
02303175	PMS-OLANZAPINE	PMS
02403099	RAN-OLANZAPINE	RBY
02337150	RIVA-OLANZAPINE	RIV
02310384	SANDOZ OLANZAPINE	SDZ
02276747	TEVA-OLANZAPINE	TEV
02229285	ZYPREXA	LIL

15MG TABLET

02325691	ACT OLANZAPINE	ACG
02281848	APO-OLANZAPINE	APX
02417294	JAMP-OLANZAPINE	JMP
02421275	MAR-OLANZAPINE	MAR
02337916	MYLAN-OLANZAPINE	MYL
02312018	OLANZAPINE	PDL
02372851	OLANZAPINE	SAN
02385902	OLANZAPINE	SIV
02303183	PMS-OLANZAPINE	PMS
02403102	RAN-OLANZAPINE	RBY
02337169	RIVA-OLANZAPINE	RIV
02310392	SANDOZ OLANZAPINE	SDZ
02276755	TEVA-OLANZAPINE	TEV
02238850	ZYPREXA	LIL

20MG TABLET

02417308	JAMP-OLANZAPINE	JMP

5MG TABLET (ORALLY DISINTEGRATING)

02327562	ACT OLANZAPINE ODT	ACG
02360616	APO-OLANZAPINE ODT	APX
02448726	AURO-OLANZAPINE ODT	AUR

28:16.08 ANTIPSYCHOTIC AGENTS

OLANZAPINE

5MG TABLET (ORALLY DISINTEGRATING)

02406624	JAMP OLANZAPINE ODT	JMP
02389088	MAR-OLANZAPINE ODT	MAR
02436965	MINT-OLANZAPINE ODT	MIN
02338645	OLANZAPINE ODT	PDL
02343665	OLANZAPINE ODT	SIV
02352974	OLANZAPINE ODT	SAN
02303191	PMS-OLANZAPINE ODT	PMS
02414090	RAN-OLANZAPINE ODT	RBY
02327775	SANDOZ OLANZAPINE ODT	SDZ
02243086	ZYPREXA ZYDIS	LIL

10MG TABLET (ORALLY DISINTEGRATING)

02327570	ACT OLANZAPINE ODT	ACG
02360624	APO-OLANZAPINE ODT	APX
02448734	AURO-OLANZAPINE ODT	AUR
02406632	JAMP OLANZAPINE ODT	JMP
02389096	MAR-OLANZAPINE ODT	MAR
02436973	MINT-OLANZAPINE ODT	MIN
02338653	OLANZAPINE ODT	PDL
02343673	OLANZAPINE ODT	SIV
02352982	OLANZAPINE ODT	SAN
02303205	PMS-OLANZAPINE ODT	PMS
02414104	RAN-OLANZAPINE ODT	RBY
02327783	SANDOZ OLANZAPINE ODT	SDZ
02243087	ZYPREXA ZYDIS	LIL

15MG TABLET (ORALLY DISINTEGRATING)

02327589	ACT OLANZAPINE ODT	ACG
02360632	APO-OLANZAPINE ODT	APX
02448742	AURO-OLANZAPINE ODT	AUR
02406640	JAMP OLANZAPINE ODT	JMP
02389118	MAR-OLANZAPINE ODT	MAR
02436981	MINT-OLANZAPINE ODT	MIN
02338661	OLANZAPINE ODT	PDL
02343681	OLANZAPINE ODT	SIV
02352990	OLANZAPINE ODT	SAN
02303213	PMS-OLANZAPINE ODT	PMS
02414112	RAN-OLANZAPINE ODT	RBY
02327791	SANDOZ OLANZAPINE ODT	SDZ
02243088	ZYPREXA ZYDIS	LIL

PALIPERIDONE PALMITATE

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:

- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

50MG/0.5ML SUSPENSION (EXTENDED RELEASE)

02354217	INVEGA SUSTENNA	JSO

75MG/0.75ML SUSPENSION (EXTENDED RELEASE)

02354225	INVEGA SUSTENNA	JSO

28:16.08 ANTIPSYCHOTIC AGENTS

PALIPERIDONE PALMITATE

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:
- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

100MG/ML SUSPENSION (EXTENDED RELEASE)

02354233	INVEGA SUSTENNA	JSO

150MG/1.5ML SUSPENSION (EXTENDED RELEASE)

02354241	INVEGA SUSTENNA	JSO

PERICYAZINE

5MG CAPSULE

01926780	NEULEPTIL	ERF

10MG CAPSULE

01926772	NEULEPTIL	ERF

20MG CAPSULE

01926764	NEULEPTIL	ERF

10MG/ML DROP

01926756	NEULEPTIL	ERF

PERPHENAZINE

3.2MG/ML LIQUID

00751898	PMS PERPHENAZINE	PMS

2MG TABLET

00335134	PERPHENAZINE	AAP

4MG TABLET

00335126	PERPHENAZINE	AAP

8MG TABLET

00335118	PERPHENAZINE	AAP

16MG TABLET

00335096	PERPHENAZINE	AAP
00726206	PMS PERPHENAZINE	PMS

PIMOZIDE

2MG TABLET

00313815	ORAP	AAP
02245432	PIMOZIDE	AAP

4MG TABLET

00313823	ORAP	AAP
02245433	PIMOZIDE	AAP

PIPOTIAZINE PALMITATE

50MG/ML INJECTION

00894672	PIPORTIL L4	SAC

PROCHLORPERAZINE

10MG SUPPOSITORY

00753688	PMS-PROCHLORPERAZINE	PMS
00789720	SANDOZ PROCHLORPERAZINE	SDZ

28:16.08 ANTIPSYCHOTIC AGENTS

PROCHLORPERAZINE MALEATE

5MG TABLET

00753661	PMS-PROCHLORPERAZINE	PMS
00886440	PROCHLORAZINE	AAP

10MG TABLET

00753637	PMS-PROCHLORPERAZINE	PMS
00886432	PROCHLORAZINE	AAP

PROCHLORPERAZINE MESYLATE

5MG/ML SOLUTION

00753645	PMS PROCHLORPERAZINE	PMS

QUETIAPINE FUMARATE

25MG TABLET

02316080	ACT QUETIAPINE	ACG
02313901	APO-QUETIAPINE	APX
02390205	AURO-QUETIAPINE	AUR
02447193	BIO-QUETIAPINE	BMI
02298996	DOM-QUETIAPINE	DPC
02330415	JAMP-QUETIAPINE	JMP
02438003	MINT-QUETIAPINE	MIN
02439158	NAT-QUETIAPINE	NPH
02296551	PMS-QUETIAPINE	PMS
02317346	PRO-QUETIAPINE	PDL
02317893	QUETIAPINE	SIV
02353164	QUETIAPINE	SAN
02387794	QUETIAPINE	ACC
02397099	RAN-QUETIAPINE	RBY
02316692	RIVA-QUETIAPINE	RIV
02313995	SANDOZ QUETIAPINE	SDZ
02236951	SEROQUEL	AZC
02284235	TEVA-QUETIAPINE	TEV
02434024	VAN-QUETIAPINE	VAN

50MG TABLET

02361892	PMS-QUETIAPINE	PMS

100MG TABLET

02316099	ACT QUETIAPINE	ACG
02313928	APO-QUETIAPINE	APX
02390213	AURO-QUETIAPINE	AUR
02447207	BIO-QUETIAPINE	BMI
02299003	DOM-QUETIAPINE	DPC
02330423	JAMP-QUETIAPINE	JMP
02438011	MINT-QUETIAPINE	MIN
02439166	NAT-QUETIAPINE	NPH
02296578	PMS-QUETIAPINE	PMS
02317354	PRO-QUETIAPINE	PDL
02317907	QUETIAPINE	SIV
02353172	QUETIAPINE	SAN
02387808	QUETIAPINE	ACC
02397102	RAN-QUETIAPINE	RBY
02316706	RIVA-QUETIAPINE	RIV
02314002	SANDOZ QUETIAPINE	SDZ
02236952	SEROQUEL	AZC
02284243	TEVA-QUETIAPINE	TEV
02434032	VAN-QUETIAPINE	VAN

200MG TABLET

02316110	ACT QUETIAPINE	ACG

28:16.08 ANTIPSYCHOTIC AGENTS

QUETIAPINE FUMARATE

200MG TABLET

02313936	APO-QUETIAPINE	APX
02390248	AURO-QUETIAPINE	AUR
02447223	BIO-QUETIAPINE	BMI
02299038	DOM-QUETIAPINE	DPC
02330458	JAMP-QUETIAPINE	JMP
02438046	MINT-QUETIAPINE	MIN
02439182	NAT-QUETIAPINE	NPH
02296594	PMS-QUETIAPINE	PMS
02317362	PRO-QUETIAPINE	PDL
02317923	QUETIAPINE	SIV
02353199	QUETIAPINE	SAN
02387824	QUETIAPINE	ACC
02397110	RAN-QUETIAPINE	RBY
02316722	RIVA-QUETIAPINE	RIV
02314010	SANDOZ QUETIAPINE	SDZ
02236953	SEROQUEL	AZC
02284278	TEVA-QUETIAPINE	TEV
02434040	VAN-QUETIAPINE	VAN

300MG TABLET

02316129	ACT QUETIAPINE	ACG
02313944	APO-QUETIAPINE	APX
02390256	AURO-QUETIAPINE	AUR
02447258	BIO-QUETIAPINE	BMI
02299046	DOM-QUETIAPINE	DPC
02330466	JAMP-QUETIAPINE	JMP
02438054	MINT-QUETIAPINE	MIN
02439190	NAT-QUETIAPINE	NPH
02296608	PMS-QUETIAPINE	PMS
02317370	PRO-QUETIAPINE	PDL
02317931	QUETIAPINE	SIV
02353202	QUETIAPINE	SAN
02387832	QUETIAPINE	ACC
02397129	RAN-QUETIAPINE	RBY
02316730	RIVA-QUETIAPINE	RIV
02314029	SANDOZ QUETIAPINE	SDZ
02244107	SEROQUEL	AZC
02284286	TEVA-QUETIAPINE	TEV
02434059	VAN-QUETIAPINE	VAN

50MG TABLET (EXTENDED RELEASE)

02417359	QUETIAPINE XR	SIV
02417782	QUETIAPINE XR	PDL
02407671	SANDOZ QUETIAPINE XRT	SDZ
02300184	SEROQUEL XR	AZC
02395444	TEVA-QUETIAPINE XR	TEV

150MG TABLET (EXTENDED RELEASE)

02417367	QUETIAPINE XR	SIV
02417790	QUETIAPINE XR	PDL
02407698	SANDOZ QUETIAPINE XRT	SDZ
02321513	SEROQUEL XR	AZC
02395452	TEVA-QUETIAPINE XR	TEV

200MG TABLET (EXTENDED RELEASE)

02417375	QUETIAPINE XR	SIV
02417804	QUETIAPINE XR	PDL
02407701	SANDOZ QUETIAPINE XRT	SDZ

28:16.08 ANTIPSYCHOTIC AGENTS

QUETIAPINE FUMARATE

200MG TABLET (EXTENDED RELEASE)

02300192	SEROQUEL XR	AZC
02395460	TEVA-QUETIAPINE XR	TEV

300MG TABLET (EXTENDED RELEASE)

02417383	QUETIAPINE XR	SIV
02417812	QUETIAPINE XR	PDL
02407728	SANDOZ QUETIAPINE XRT	SDZ
02300206	SEROQUEL XR	AZC
02395479	TEVA-QUETIAPINE XR	TEV

400MG TABLET (EXTENDED RELEASE)

02417391	QUETIAPINE XR	SIV
02417820	QUETIAPINE XR	PDL
02407736	SANDOZ QUETIAPINE XRT	SDZ
02300214	SEROQUEL XR	AZC
02395487	TEVA-QUETIAPINE XR	TEV

25MG TABLET (IMMEDIATE RELEASE)

02399822	MAR-QUETIAPINE	MAR

100MG TABLET (IMMEDIATE RELEASE)

02399830	MAR-QUETIAPINE	MAR

200MG TABLET (IMMEDIATE RELEASE)

02399849	MAR-QUETIAPINE	MAR

300MG TABLET (IMMEDIATE RELEASE)

02399857	MAR-QUETIAPINE	MAR

RISPERIDONE

1MG SOLUTION

02454319	JAMP-RISPERIDONE	JMP

1MG/ML SOLUTION

02280396	APO-RISPERIDONE	APX
02279266	PMS-RISPERIDONE	PMS
02236950	RISPERDAL	JSO

0.25MG TABLET

02282585	ACT RISPERIDONE	ACG
02282119	APO-RISPERIDONE	APX
02359529	JAMP-RISPERIDONE	JMP
02371766	MAR-RISPERIDONE	MAR
02359790	MINT-RISPERIDON	MIN
02282240	MYLAN-RISPERIDONE	MYL
02252007	PMS-RISPERIDONE	PMS
02312700	PRO-RISPERIDONE	PDL
02328305	RAN-RISPERIDONE	RBY
02240551	RISPERDAL	JSO
02356880	RISPERIDONE	SAN
02283565	RIVA-RISPERIDONE	RIV
02303655	SANDOZ RISPERIDONE	SDZ
02282690	TEVA-RISPERIDONE	TEV

0.5MG TABLET

02282593	ACT RISPERIDONE	ACG
02282127	APO-RISPERIDONE	APX
02359537	JAMP-RISPERIDONE	JMP
02371774	MAR-RISPERIDONE	MAR
02359804	MINT-RISPERIDON	MIN
02282259	MYLAN-RISPERIDONE	MYL
02252015	PMS-RISPERIDONE	PMS
02312719	PRO-RISPERIDONE	PDL

28:16.08 ANTIPSYCHOTIC AGENTS

RISPERIDONE

0.5MG TABLET

02328313	RAN-RISPERIDONE	RBY
02240552	RISPERDAL	JSO
02356899	RISPERIDONE	SAN
02283573	RIVA-RISPERIDONE	RIV
02303663	SANDOZ RISPERIDONE	SDZ
02264188	TEVA-RISPERIDONE	TEV

1MG TABLET

02282607	ACT RISPERIDONE	ACG
02282135	APO-RISPERIDONE	APX
02359545	JAMP-RISPERIDONE	JMP
02371782	MAR-RISPERIDONE	MAR
02359812	MINT-RISPERIDON	MIN
02252023	PMS-RISPERIDONE	PMS
02312727	PRO-RISPERIDONE	PDL
02328321	RAN-RISPERIDONE	RBY
02025280	RISPERDAL	JSO
02356902	RISPERIDONE	SAN
02283581	RIVA-RISPERIDONE	RIV
02279800	SANDOZ RISPERIDONE	SDZ
02264196	TEVA-RISPERIDONE	TEV

2MG TABLET

02282615	ACT RISPERIDONE	ACG
02282143	APO-RISPERIDONE	APX
02359553	JAMP-RISPERIDONE	JMP
02371790	MAR-RISPERIDONE	MAR
02359820	MINT-RISPERIDON	MIN
02252031	PMS-RISPERIDONE	PMS
02312735	PRO-RISPERIDONE	PDL
02328348	RAN-RISPERIDONE	RBY
02025299	RISPERDAL	JSO
02356910	RISPERIDONE	SAN
02283603	RIVA-RISPERIDONE	RIV
02279819	SANDOZ RISPERIDONE	SDZ
02264218	TEVA-RISPERIDONE	TEV

3MG TABLET

02282623	ACT RISPERIDONE	ACG
02282151	APO-RISPERIDONE	APX
02359561	JAMP-RISPERIDONE	JMP
02371804	MAR-RISPERIDONE	MAR
02359839	MINT-RISPERIDON	MIN
02252058	PMS-RISPERIDONE	PMS
02312743	PRO-RISPERIDONE	PDL
02328364	RAN-RISPERIDONE	RBY
02025302	RISPERDAL	JSO
02356929	RISPERIDONE	SAN
02283611	RIVA-RISPERIDONE	RIV
02279827	SANDOZ RISPERIDONE	SDZ
02264226	TEVA-RISPERIDONE	TEV

4MG TABLET

02282631	ACT RISPERIDONE	ACG
02282178	APO-RISPERIDONE	APX
02359588	JAMP-RISPERIDONE	JMP
02371812	MAR-RISPERIDONE	MAR
02359847	MINT-RISPERIDON	MIN
02252066	PMS-RISPERIDONE	PMS
02312751	PRO-RISPERIDONE	PDL
02328372	RAN-RISPERIDONE	RBY
02025310	RISPERDAL	JSO
02356937	RISPERIDONE	SAN
02283638	RIVA-RISPERIDONE	RIV
02279835	SANDOZ RISPERIDONE	SDZ
02264234	TEVA-RISPERIDONE	TEV

0.5MG TABLET (ORALLY DISINTEGRATING)

02413485	MYLAN-RISPERIDONE ODT	MYL

1MG TABLET (ORALLY DISINTEGRATING)

02413493	MYLAN-RISPERIDONE ODT	MYL
02291789	PMS-RISPERIDONE ODT	PMS

2MG TABLET (ORALLY DISINTEGRATING)

02413507	MYLAN-RISPERIDONE ODT	MYL
02291797	PMS-RISPERIDONE ODT	PMS

3MG TABLET (ORALLY DISINTEGRATING)

02413515	MYLAN-RISPERIDONE ODT	MYL
02370697	PMS-RISPERIDONE ODT	PMS

4MG TABLET (ORALLY DISINTEGRATING)

02413523	MYLAN-RISPERIDONE ODT	MYL
02370700	PMS-RISPERIDONE ODT	PMS

RISPERIDONE (CONSTA)

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:
- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

12.5MG INJECTION

02298465	RISPERDAL CONSTA	JSO

25MG INJECTION

02255707	RISPERDAL CONSTA	JSO

37.5MG INJECTION

02255723	RISPERDAL CONSTA	JSO

50MG INJECTION

02255758	RISPERDAL CONSTA	JSO

THIOPROPERAZINE MESYLATE

10MG TABLET

01927639	MAJEPTIL	ERF

THIOTHIXENE

5MG CAPSULE

00024449	NAVANE	ERF

TRIFLUOPERAZINE HYDROCHLORIDE

1MG TABLET

00345539	TRIFLUOPERAZINE	AAP

28:16.08 ANTIPSYCHOTIC AGENTS

TRIFLUOPERAZINE HYDROCHLORIDE

2MG TABLET

00312754	TRIFLUOPERAZINE	AAP

5MG TABLET

00312746	TRIFLUOPERAZINE	AAP

10MG TABLET

00326836	TRIFLUOPERAZINE	AAP

20MG TABLET

00595942	TRIFLUOPERAZINE	AAP

ZIPRASIDONE HYDROCHLORIDE MONOHYDRATE

20MG CAPSULE

02298597	ZELDOX	PFI

40MG CAPSULE

02298600	ZELDOX	PFI

60MG CAPSULE

02298619	ZELDOX	PFI

80MG CAPSULE

02298627	ZELDOX	PFI

ZUCLOPENTHIXOL ACETATE

50MG/ML SOLUTION

02230405	CLOPIXOL-ACUPHASE	LUD

ZUCLOPENTHIXOL DIHYDROCHLORIDE

200MG/ML SOLUTION

02230406	CLOPIXOL DEPOT	LUD

10MG TABLET

02230402	CLOPIXOL	LUD

25MG TABLET

02230403	CLOPIXOL	LUD

28:20.04 AMPHETAMINES

DEXTROAMPHETAMINE SULFATE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

10MG CAPSULE (SUSTAINED RELEASE)

01924559	DEXEDRINE SPANSULE	PAL

15MG CAPSULE (SUSTAINED RELEASE)

01924567	DEXEDRINE SPANSULE	PAL

5MG TABLET

02443236	APO-DEXTROAMPHETAMINE	APX
01924516	DEXEDRINE	PAL

28:20.04 AMPHETAMINES

LISDEXAMFETAMINE DIMESYLATE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

10MG CAPSULE

02439603	VYVANSE	SHI

20MG CAPSULE

02347156	VYVANSE	SHI

30MG CAPSULE

02322951	VYVANSE	SHI

40MG CAPSULE

02347164	VYVANSE	SHI

50MG CAPSULE

02322978	VYVANSE	SHI

60MG CAPSULE

02347172	VYVANSE	SHI

28:20.32 CNS STIMULANTS

METHYLPHENIDATE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

5MG TABLET

02273950	APO-METHYLPHENIDATE	APX
02326221	METHYLPHENIDATE	PDL
02234749	PMS-METHYLPHENIDATE	PMS

10MG TABLET

02249324	APO-METHYLPHENIDATE	APX
02326248	METHYLPHENIDATE	PDL
00584991	PMS-METHYLPHENIDATE	PMS

20MG TABLET

02249332	APO-METHYLPHENIDATE	APX
02326256	METHYLPHENIDATE	PDL
00585009	PMS-METHYLPHENIDATE	PMS

18MG TABLET (EXTENDED RELEASE)

02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO

28:20.32 CNS STIMULANTS

METHYLPHENIDATE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

18MG TABLET (EXTENDED RELEASE)

02413728	PMS-METHYLPHENIDATE ER	PMS
02315068	TEVA-METHYLPHENIDATE	TEV

20MG TABLET (EXTENDED RELEASE)

02266687	APO-METHYLPHENIDATE SR	APX
02320312	SANDOZ METHYLPHENIDATE SR	SDZ

27MG TABLET (EXTENDED RELEASE)

02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02413736	PMS-METHYLPHENIDATE ER	PMS
02315076	TEVA-METHYLPHENIDATE	TEV

36MG TABLET (EXTENDED RELEASE)

02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02413744	PMS-METHYLPHENIDATE ER	PMS
02315084	TEVA-METHYLPHENIDATE	TEV

54MG TABLET (EXTENDED RELEASE)

02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02413752	PMS-METHYLPHENIDATE ER	PMS
02315092	TEVA-METHYLPHENIDATE	TEV

28:20.80 WAKEFULNESS-PROMOTING AGENTS

MODAFINIL

100MG TABLET

02239665	ALERTEC	TEV
02285398	APO-MODAFINIL	APX
02430487	AURO-MODAFINIL	AUR
02442078	BIO-MODAFINIL	BMI
02432560	MAR-MODAFINIL	MAR
02420260	TEVA-MODAFINIL	TEV

28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT

CAFFEINE CITRATE

Limited use benefit (prior approval not required).

For children up to 1 year of age

POWDER

00972037	CAFFEINE CITRATE	MDS

28:24.04 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BARBITURATES

PHENOBARBITAL

15MG TABLET

00178799	PHENOBARB	PED

30MG TABLET

00178802	PHENOBARB	PED

60MG TABLET

00178810	PHENOBARB	PED

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

ALPRAZOLAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

0.25MG TABLET

01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
02400111	JAMP-ALPRAZOLAM	JMP
02137534	MYLAN-ALPRAZOLAM	MYL
02417634	NAT-ALPRAZOLAM	NPH
02404877	RIVA-ALPRAZOLAM	RIV
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	PFI

0.5MG TABLET

01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
02400138	JAMP-ALPRAZOLAM	JMP
02137542	MYLAN-ALPRAZOLAM	MYL
02417642	NAT-ALPRAZOLAM	NPH
02404885	RIVA-ALPRAZOLAM	RIV
01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	PFI

1MG TABLET

02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX
02400146	JAMP-ALPRAZOLAM	JMP
02417650	NAT-ALPRAZOLAM	NPH
02404893	RIVA-ALPRAZOLAM	RIV
00723770	XANAX	PFI

2MG TABLET

02243612	APO-ALPRAZ	APX
02400154	JAMP-ALPRAZOLAM	JMP
02229814	MYLAN-ALPRAZOLAM	MYL
02404907	RIVA-ALPRAZOLAM	RIV
00813958	XANAX TS	PFI

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

BROMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

1.5MG TABLET

02177153	APO-BROMAZEPAM	APX

3MG TABLET

02177161	APO-BROMAZEPAM	APX
02220520	BROMAZEPAM	PDL
00518123	LECTOPAM	HLR
02230584	TEVA-BROMAZEPAM	TEV

6MG TABLET

02177188	APO-BROMAZEPAM	APX
02220539	BROMAZEPAM	PDL
00518131	LECTOPAM	HLR
02230585	TEVA-BROMAZEPAM	TEV

DIAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

1MG/ML SOLUTION

00891797	PMS-DIAZEPAM	PMS

2MG TABLET

00405329	APO DIAZEPAM	APX
02247490	PMS-DIAZEPAM	PMS

5MG TABLET

00362158	APO DIAZEPAM	APX
00313580	DIAZEPAM	PDL
02247491	PMS-DIAZEPAM	PMS
00013285	VALIUM	HLR

10MG TABLET

00405337	APO DIAZEPAM	APX
02247492	PMS-DIAZEPAM	PMS

DIAZEPAM (DIASTAT)

Limited use benefit (prior approval not required).

For children 12 years of age or under.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

5MG/ML GEL

02238162	DIASTAT	VAE
09853340	DIASTAT 2X10MG RECTAL PACK	ELN
09853430	DIASTAT 2X15MG RECTAL PACK	ELN

LORAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

0.5MG TABLET

00655740	APO-LORAZEPAM	APX
02410745	APO-LORAZEPAM SUBLINGUAL	APX
02041413	ATIVAN	PFI
02041456	ATIVAN SUBLINGUAL	PFI
02245784	DOM-LORAZEPAM	DPC
02351072	LORAZEPAM	SAN
00728187	PMS-LORAZEPAM	PMS
00655643	PRO-LORAZEPAM	PDL
00711101	TEVA-LORAZEPAM	TEV

1MG TABLET

00655759	APO-LORAZEPAM	APX
02410753	APO-LORAZEPAM SUBLINGUAL	APX
02041421	ATIVAN	PFI
02041464	ATIVAN SUBLINGUAL	PFI
02245785	DOM-LORAZEPAM	DPC
02351080	LORAZEPAM	SAN
00728195	PMS-LORAZEPAM	PMS
00655651	PRO-LORAZEPAM	PDL
00637742	TEVA-LORAZEPAM	TEV

2MG TABLET

00655767	APO-LORAZEPAM	APX
02410761	APO-LORAZEPAM SUBLINGUAL	APX
02041448	ATIVAN	PFI
02041472	ATIVAN SUBLINGUAL	PFI
02245786	DOM-LORAZEPAM	DPC
02351099	LORAZEPAM	SAN
00728209	PMS-LORAZEPAM	PMS
00655678	PRO-LORAZEPAM	PDL
00637750	TEVA-LORAZEPAM	TEV

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

NITRAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

5MG TABLET

00511528	MOGADON	AAP

10MG TABLET

00511536	MOGADON	AAP

OXAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

10MG TABLET

00402680	APO OXAZEPAM	APX
00497754	OXAZEPAM	PDL
00414247	OXPAM	BMI
00568392	RIVA OXAZEPAM	RIV

15MG TABLET

00402745	APO OXAZEPAM	APX
00497762	OXAZEPAM	PDL
00568406	RIVA OXAZEPAM	RIV

30MG TABLET

00402737	APO OXAZEPAM	APX
00497770	OXAZEPAM	PDL
00414263	OXPAM	BMI
00568414	RIVA OXAZEPAM	RIV

TEMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

15MG CAPSULE

02225964	APO-TEMAZEPAM	APX
00604453	RESTORIL	AAP
02229760	TEMAZEPAM	PDL
02230095	TEVA-TEMAZEPAM	TEV

30MG CAPSULE

02225972	APO-TEMAZEPAM	APX
00604461	RESTORIL	AAP

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

TEMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

30MG CAPSULE

02229761	TEMAZEPAM	PDL
02230102	TEVA-TEMAZEPAM	TEV

TRIAZOLAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

0.25MG TABLET

00808571	TRIAZOLAM	AAP

28:24.92 MISCELLANEOUS ANXIOLYTICS, SEDATIVES, AND HYPNOTICS

BUSPIRONE HYDROCHLORIDE

10MG TABLET

02211076	APO-BUSPIRONE	APX
02223163	BUSPIRONE	PDL
02447851	BUSPIRONE	SAN
02230942	PMS-BUSPIRONE	PMS
02231492	TEVA-BUSPIRONE	TEV

HYDROXYZINE HYDROCHLORIDE

10MG CAPSULE

00646059	APO HYDROXYZINE	APX
00738824	NOVO-HYDROXYZIN	TEV

25MG CAPSULE

00646024	APO HYDROXYZINE	APX
00738832	NOVO-HYDROXYZIN	TEV

50MG CAPSULE

00646016	APO HYDROXYZINE	APX
00738840	NOVO-HYDROXYZIN	TEV

2MG/ML SYRUP

00024694	ATARAX	ERF
00741817	PMS HYDROXYZINE	PMS

28:28.00 ANTIMANIC AGENTS

LITHIUM CARBONATE

150MG CAPSULE

02242837	APO-LITHIUM CARBONATE	APX
09857532	APO-LITHIUM CARBONATE	APX
00461733	CARBOLITH	VAE

28:28.00 ANTIMANIC AGENTS

LITHIUM CARBONATE

ST**150MG CAPSULE**

02013231	LITHANE	ERF
02216132	PMS-LITHIUM CARBONATE	PMS

ST**300MG CAPSULE**

02242838	APO-LITHIUM CARBONATE	APX
09857540	APO-LITHIUM CARBONATE	APX
00236683	CARBOLITH	VAE
00406775	LITHANE	ERF
02216140	PMS-LITHIUM CARBONATE	PMS

ST**600MG CAPSULE**

02011239	CARBOLITH	VAE
02216159	PMS-LITHIUM CARBONATE	PMS

ST**300MG TABLET (EXTENDED RELEASE)**

02266695	LITHMAX	AAP

LITHIUM CITRATE

ST**60MG/ML SYRUP**

02074834	PMS-LITHIUM CITRATE	PMS

28:32.28 SELECTIVE SEROTONIN AGONISTS

ALMOTRIPTAN MALATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

6.25MG TABLET

02405792	APO-ALMOTRIPTAN	APX
02248128	AXERT	MCL
02398435	MYLAN-ALMOTRIPTAN	MYL

12.5MG TABLET

02424029	ALMOTRIPTAN	PDL
02405806	APO-ALMOTRIPTAN	APX
02248129	AXERT	MCL
02398443	MYLAN-ALMOTRIPTAN	MYL
02405334	SANDOZ ALMOTRIPTAN	SDZ

NARATRIPTAN HYDROCHLORIDE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

1MG TABLET

02237820	AMERGE	GSK
02314290	TEVA-NARATRIPTAN	TEV

2.5MG TABLET

02237821	AMERGE	GSK
02322323	SANDOZ NARATRIPTAN	SDZ
02314304	TEVA-NARATRIPTAN	TEV

RIZATRIPTAN BENZOATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

5MG TABLET

02393468	APO-RIZATRIPTAN	APX
02380455	JAMP-RIZATRIPTAN	JMP

28:32.28 SELECTIVE SEROTONIN AGONISTS

RIZATRIPTAN BENZOATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

5MG TABLET

02429233	JAMP-RIZATRIPTAN IR	JMP
02379651	MAR-RIZATRIPTAN	MAR
02428512	VAN-RIZATRIPTAN	VAN

10MG TABLET

02381702	ACT RIZATRIPTAN	ACG
02393476	APO-RIZATRIPTAN	APX
02441144	AURO-RIZATRIPTAN	AUR
02380463	JAMP-RIZATRIPTAN	JMP
02429241	JAMP-RIZATRIPTAN IR	JMP
02379678	MAR-RIZATRIPTAN	MAR
02240521	MAXALT	FRS
02428520	VAN-RIZATRIPTAN	VAN

5MG TABLET (ORALLY DISINTEGRATING)

02374730	ACT RIZATRIPTAN ODT	ACG
02393484	APO-RIZATRIPTAN RPD	APX
02465086	JAMP-RIZATRIPTAN ODT	JMP
02240518	MAXALT RPD	FRS
02379198	MYLAN-RIZATRIPTAN ODT	MYL
02436604	NAT-RIZATRIPTAN ODT	NPH
02393360	PMS-RIZATRIPTAN RDT	PMS
02423456	RIVA-RIZATRIPTAN ODT	RIV
02442906	RIZATRIPTAN ODT	SAN
02446111	RIZATRIPTAN ODT	SIV
02415798	RIZATRIPTAN RDT	PDL
02351870	SANDOZ RIZATRIPTAN ODT	SDZ
02396661	TEVA-RIZATRIPTAN ODT	TEV

10MG TABLET (ORALLY DISINTEGRATING)

02374749	ACT RIZATRIPTAN ODT	ACG
02393492	APO-RIZATRIPTAN RPD	APX
02396203	DOM-RIZATRIPTAN RDT	DPC
02465094	JAMP-RIZATRIPTAN ODT	JMP
02240519	MAXALT RPD	FRS
02379201	MYLAN-RIZATRIPTAN ODT	MYL
02436612	NAT-RIZATRIPTAN ODT	NPH
02393379	PMS-RIZATRIPTAN RDT	PMS
02423464	RIVA-RIZATRIPTAN ODT	RIV
02442914	RIZATRIPTAN ODT	SAN
02446138	RIZATRIPTAN ODT	SIV
02415801	RIZATRIPTAN RDT	PDL
02351889	SANDOZ RIZATRIPTAN ODT	SDZ
02396688	TEVA-RIZATRIPTAN ODT	TEV
02448505	VAN-RIZATRIPTAN ODT	VAN

SUMATRIPTAN HEMISULFATE

5MG SPRAY

02230418	IMITREX	GSK

20MG SPRAY

02230420	IMITREX	GSK

28:32.28 SELECTIVE SEROTONIN AGONISTS

SUMATRIPTAN SUCCINATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

6MG/0.5ML INJECTION

99000598	IMITREX STAT DOSE KIT	GSK

12MG/ML SOLUTION

02212188	IMITREX	GSK
02361698	TARO-SUMATRIPTAN	TAR

25MG TABLET

02257882	ACT SUMATRIPTAN	ACG
02270749	DOM-SUMATRIPTAN	DPC
02268906	MYLAN-SUMATRIPTAN	MYL
02256428	PMS-SUMATRIPTAN	PMS
02286815	TEVA-SUMATRIPTAN DF	TEV

50MG TABLET

02257890	ACT SUMATRIPTAN	ACG
02268388	APO-SUMATRIPTAN	APX
02270757	DOM-SUMATRIPTAN	DPC
02212153	IMITREX DF	GSK
02268914	MYLAN-SUMATRIPTAN	MYL
02256436	PMS-SUMATRIPTAN	PMS
02263025	SANDOZ SUMATRIPTAN	SDZ
02286521	SUMATRIPTAN	SAN
02324652	SUMATRIPTAN	PDL
02385570	SUMATRIPTAN DF	SIV
02286823	TEVA-SUMATRIPTAN DF	TEV

100MG TABLET

02257904	ACT SUMATRIPTAN	ACG
02268396	APO-SUMATRIPTAN	APX
02270765	DOM-SUMATRIPTAN	DPC
02212161	IMITREX DF	GSK
02268922	MYLAN-SUMATRIPTAN	MYL
02256444	PMS-SUMATRIPTAN	PMS
02263033	SANDOZ SUMATRIPTAN	SDZ
02286548	SUMATRIPTAN	SAN
02324660	SUMATRIPTAN	PDL
02385589	SUMATRIPTAN DF	SIV
02239367	TEVA-SUMATRIPTAN	TEV
02286831	TEVA-SUMATRIPTAN DF	TEV

ZOLMITRIPTAN

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

2.5MG TABLET

02380951	APO-ZOLMITRIPTAN	APX
02389525	DOM-ZOLMITRIPTAN	DPC
02421623	JAMP-ZOLMITRIPTAN	JMP
02399458	MAR-ZOLMITRIPTAN	MAR
02419521	MINT-ZOLMITRIPTAN	MIN
02369036	MYLAN-ZOLMITRIPTAN	MYL
02421534	NAT-ZOLMITRIPTAN	NPH
02324229	PMS-ZOLMITRIPTAN	PMS
02401304	RIVA-ZOLMITRIPTAN	RIV

28:32.28 SELECTIVE SEROTONIN AGONISTS

ZOLMITRIPTAN

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

2.5MG TABLET

02362988	SANDOZ ZOLMITRIPTAN	SDZ
02313960	TEVA-ZOLMITRIPTAN	TEV
02379929	ZOLMITRIPTAN	PDL
02238660	ZOMIG	AZC

2.5MG TABLET (ORALLY DISINTEGRATING)

02438453	AG-ZOLMITRIPTAN ODT	ANG
02381575	APO-ZOLMITRIPTAN RAPID	APX
02428237	JAMP-ZOLMITRIPTAN ODT	JMP
02387158	MYLAN-ZOLMITRIPTAN ODT	MYL
02324768	PMS-ZOLMITRIPTAN ODT	PMS
02362996	SANDOZ ZOLMITRIPTAN ODT	SDZ
02428474	SEPTA-ZOLMITRIPTAN-ODT	SPT
02342545	TEVA-ZOLMITRIPTAN OD	TEV
02438763	VAN-ZOLMITRIPTAN ODT	VAN
02379988	ZOLMITRIPTAN ODT	PDL
02243045	ZOMIG RAPIMELT	AZC

28:32.92 MISCELLANEOUS ANTIMIGRANE AGENTS

FLUNARIZINE HYDROCHLORIDE

5MG CAPSULE

02246082	FLUNARIZINE	AAP

PIZOTIFEN MALATE

0.5MG TABLET

00329320	SANDOMIGRAN	PAL

1MG TABLET

00511552	SANDOMIGRAN DS	PAL

28:36.08 ANTIPARKINSONIAN AGENTS - ANTICHOLINERGIC AGENTS

BENZTROPINE MESYLATE

1MG/ML LIQUID

02238903	BENZTROPINE OMEGA	OMG

1MG TABLET

00706531	PDP-BENZTROPINE	PED

2MG TABLET

00426857	PDP-BENZTROPINE	PED
00587265	PMS-BENZTROPINE	PMS

ETHOPROPAZINE HYDROCHLORIDE

50MG TABLET

01927744	PARSITAN	ERF

PROCYCLIDINE HYDROCHLORIDE

0.5MG/ML ELIXIR

00587362	PDP-PROCYCLIDINE	PED

2.5MG TABLET

00649392	PDP-PROCYCLIDINE	PED

5MG TABLET

00587354	PDP-PROCYCLIDINE	PED

28:36.08 ANTIPARKINSONIAN AGENTS - ANTICHOLINERGIC AGENTS

TRIHEXYPHENIDYL HYDROCHLORIDE

0.4MG/ML ELIXIR

00885398	PMS-TRIHEXYPHENIDYL	PMS

2MG TABLET

00545058	TRIHEXYPHENIDYL	AAP

5MG TABLET

00545074	TRIHEXYPHENIDYL	AAP

28:36.12 ANTIPARKINSONIAN AGENTS - CATECHOL-O-METHYLTRANSFERASE (COMT) INHIBITORS

ENTACAPONE

ST **200MG TABLET**

02243763	COMTAN	NVR
02380005	SANDOZ ENTACAPONE	SDZ
02375559	TEVA-ENTACAPONE	TEV

28:36.16 ANTIPARKINSONIAN AGENTS - DOPAMINE PRECURSORS

LEVODOPA, BENSERAZIDE HYDROCHLORIDE

ST **50MG & 12.5MG CAPSULE**

00522597	PROLOPA	HLR

ST **100MG & 25MG CAPSULE**

00386464	PROLOPA	HLR

ST **200MG & 50MG CAPSULE**

00386472	PROLOPA	HLR

LEVODOPA, CARBIDOPA

ST **100MG & 10MG TABLET**

02195933	APO-LEVOCARB	APX
02457954	MINT-LEVOCARB	MIN
02244494	TEVA-LEVOCARBIDOPA	TEV

ST **100MG & 25MG TABLET**

02195941	APO-LEVOCARB	APX
02457962	MINT-LEVOCARB	MIN
02421488	PMS-LEVOCARB	PMS
02311178	PRO-LEVOCARB	PDL
00513997	SINEMET	FRS
02244495	TEVA-LEVOCARBIDOPA	TEV

ST **250MG & 25MG TABLET**

02195968	APO-LEVOCARB	APX
02457970	MINT-LEVOCARB	MIN
00328219	SINEMET	FRS
02244496	TEVA-LEVOCARBIDOPA	TEV

ST **100MG & 25MG TABLET (EXTENDED RELEASE)**

02272873	APO-LEVOCARB	APX
02028786	SINEMET	FRS

ST **200MG & 50MG TABLET (EXTENDED RELEASE)**

02245211	APO-LEVOCARB	APX
02421496	PMS-LEVOCARB	PMS
00870935	SINEMET	FRS

28:36.16 ANTIPARKINSONIAN AGENTS - DOPAMINE PRECURSORS

LEVODOPA, CARBIDOPA, ENTACAPONE

ST **50MG & 12.5MG & 200MG TABLET**

02305933	STALEVO	NVR

ST **75MG & 18.75MG & 200MG TABLET**

02337827	STALEVO	NVR

ST **100MG & 25MG & 200MG TABLET**

02305941	STALEVO	NVR

ST **125MG & 31.25MG & 200MG TABLET**

02337835	STALEVO	NVR

ST **150MG & 37.5MG & 200MG TABLET**

02305968	STALEVO	NVR

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

BROMOCRIPTINE MESYLATE

ST **5MG CAPSULE**

02230454	BROMOCRIPTINE	AAP
02238637	DOM-BROMOCRIPTINE	DPC
02236949	PMS-BROMOCRIPTINE	PMS

ST **2.5MG TABLET**

02087324	BROMOCRIPTINE	AAP
02238636	DOM-BROMOCRIPTINE	DPC
02231702	PMS-BROMOCRIPTINE	PMS

CABERGOLINE

Limited use benefit (prior approval required).

For treatment of hyperprolactinemia in patients who have failed therapy with or are intolerant to bromocriptine.

0.5MG TABLET

02301407	ACT CABERGOLINE	ACG
02455897	APO-CABERGOLINE	APX
02242471	DOSTINEX	PFI

PRAMIPEXOLE DIHYDROCHLORIDE

ST **0.25MG TABLET**

02297302	ACT PRAMIPEXOLE	ACG
02292378	APO-PRAMIPEXOLE	APX
02424061	AURO-PRAMIPEXOLE	AUR
02309017	DOM-PRAMIPEXOLE	DPC
02237145	MIRAPEX	BOE
09857268	MIRAPEX (ON)	BOE
02290111	PMS-PRAMIPEXOLE	PMS
02309122	PRAMIPEXOLE	SIV
02325802	PRAMIPEXOLE	PDL
02367602	PRAMIPEXOLE	SAN
02315262	SANDOZ PRAMIPEXOLE	SDZ
02269309	TEVA-PRAMIPEXOLE	TEV

ST **0.5MG TABLET**

02297310	ACT PRAMIPEXOLE	ACG
02292386	APO-PRAMIPEXOLE	APX
02424088	AURO-PRAMIPEXOLE	AUR
02241594	MIRAPEX	BOE
02290138	PMS-PRAMIPEXOLE	PMS
02309130	PRAMIPEXOLE	SIV

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

PRAMIPEXOLE DIHYDROCHLORIDE

ST **0.5MG TABLET**

02325810	PRAMIPEXOLE	PDL
02367610	PRAMIPEXOLE	SAN
02315270	SANDOZ PRAMIPEXOLE	SDZ
02269317	TEVA-PRAMIPEXOLE	TEV

ST **1MG TABLET**

02297329	ACT PRAMIPEXOLE	ACG
02292394	APO-PRAMIPEXOLE	APX
02424096	AURO-PRAMIPEXOLE	AUR
02237146	MIRAPEX	BOE
09857269	MIRAPEX (ON)	BOE
02290146	PMS-PRAMIPEXOLE	PMS
02309149	PRAMIPEXOLE	SIV
02325829	PRAMIPEXOLE	PDL
02367629	PRAMIPEXOLE	SAN
02315289	SANDOZ PRAMIPEXOLE	SDZ
02269325	TEVA-PRAMIPEXOLE	TEV

ST **1.5MG TABLET**

02297337	ACT PRAMIPEXOLE	ACG
02292408	APO-PRAMIPEXOLE	APX
02424118	AURO-PRAMIPEXOLE	AUR
02237147	MIRAPEX	BOE
09857270	MIRAPEX (ON)	BOE
02290154	PMS-PRAMIPEXOLE	PMS
02309157	PRAMIPEXOLE	SIV
02325837	PRAMIPEXOLE	PDL
02315297	SANDOZ PRAMIPEXOLE	SDZ
02269333	TEVA-PRAMIPEXOLE	TEV

ROPINIROLE HYDROCHLORIDE

ST **0.25MG TABLET**

02316846	ACT ROPINIROLE	ACG
02337746	APO-ROPINIROLE	APX
02352338	JAMP-ROPINIROLE	JMP
02326590	PMS-ROPINIROLE	PMS
02314037	RAN-ROPINIROLE	RBY
02353040	ROPINIROLE	SAN

ST **1MG TABLET**

02316854	ACT ROPINIROLE	ACG
02337762	APO-ROPINIROLE	APX
02352346	JAMP-ROPINIROLE	JMP
02326612	PMS-ROPINIROLE	PMS
02314053	RAN-ROPINIROLE	RBY
02232567	REQUIP	GSK
02353059	ROPINIROLE	SAN

ST **2MG TABLET**

02316862	ACT ROPINIROLE	ACG
02337770	APO-ROPINIROLE	APX
02352354	JAMP-ROPINIROLE	JMP
02326620	PMS-ROPINIROLE	PMS
02314061	RAN-ROPINIROLE	RBY
02232568	REQUIP	GSK

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

ROPINIROLE HYDROCHLORIDE

ST **5MG TABLET**

02316870	ACT ROPINIROLE	ACG
02337800	APO-ROPINIROLE	APX
02352362	JAMP-ROPINIROLE	JMP
02326639	PMS-ROPINIROLE	PMS
02314088	RAN-ROPINIROLE	RBY
02232569	REQUIP	GSK

ROTIGOTINE

Limited use benefit (prior approval required).

As an adjunct to levodopa for the treatment of patients with advanced stage Parkinson's disease; AND
Patient is currently receiving treatment with levodopa.

2MG PATCH

02403900	NEUPRO	UCB

4MG PATCH

02403927	NEUPRO	UCB

6MG PATCH

02403935	NEUPRO	UCB

8MG PATCH

02403943	NEUPRO	UCB

28:36.32 ANTIPARKINSONIAN AGENTS - MONOAMINE OXIDASE B INHIBITORS

SELEGILINE HYDROCHLORIDE

ST **5MG TABLET**

02230641	APO-SELEGILINE	APX
02068087	TEVA-SELEGILINE	TEV

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ACAMPROSATE CALCIUM

Limited use benefit (prior approval required).

For patients who have been abstinent from alcohol for at least four days and where available, are currently enrolled in an alcohol addiction treatment program.

333MG TABLET (DELAYED RELEASE)

02293269	CAMPRAL	MYL

ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:

- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

10MG CAPSULE

02318024	APO-ATOMOXETINE	APX
02358190	ATOMOXETINE	AAP

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:
- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

10MG CAPSULE

02396904	ATOMOXETINE	PDL
02445883	ATOMOXETINE	SIV
02390469	DOM-ATOMOXETINE	DPC
02381028	PMS-ATOMOXETINE	PMS
02405962	RIVA-ATOMOXETINE	RIV
02386410	SANDOZ ATOMOXETINE	SDZ
02262800	STRATTERA	LIL
02314541	TEVA-ATOMOXETINE	TEV

18MG CAPSULE

02318032	APO-ATOMOXETINE	APX
02358204	ATOMOXETINE	AAP
02396912	ATOMOXETINE	PDL
02445905	ATOMOXETINE	SIV
02390477	DOM-ATOMOXETINE	DPC
02378930	MYLAN-ATOMOXETINE	MYL
02381036	PMS-ATOMOXETINE	PMS
02386429	SANDOZ ATOMOXETINE	SDZ
02262819	STRATTERA	LIL
02314568	TEVA-ATOMOXETINE	TEV

25MG CAPSULE

02318040	APO-ATOMOXETINE	APX
02358212	ATOMOXETINE	AAP
02396920	ATOMOXETINE	PDL
02445913	ATOMOXETINE	SIV
02390485	DOM-ATOMOXETINE	DPC
02378949	MYLAN-ATOMOXETINE	MYL
02381044	PMS-ATOMOXETINE	PMS
02405989	RIVA-ATOMOXETINE	RIV
02386437	SANDOZ ATOMOXETINE	SDZ
02262827	STRATTERA	LIL
02314576	TEVA-ATOMOXETINE	TEV

40MG CAPSULE

02318059	APO-ATOMOXETINE	APX
02358220	ATOMOXETINE	AAP
02396939	ATOMOXETINE	PDL
02445948	ATOMOXETINE	SIV
02390493	DOM-ATOMOXETINE	DPC
02378957	MYLAN-ATOMOXETINE	MYL
02381052	PMS-ATOMOXETINE	PMS
02405997	RIVA-ATOMOXETINE	RIV
02386445	SANDOZ ATOMOXETINE	SDZ
02262835	STRATTERA	LIL
02314584	TEVA-ATOMOXETINE	TEV

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:
- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

60MG CAPSULE

02318067	APO-ATOMOXETINE	APX
02358239	ATOMOXETINE	AAP
02396947	ATOMOXETINE	PDL
02445956	ATOMOXETINE	SIV
02390515	DOM-ATOMOXETINE	DPC
02378965	MYLAN-ATOMOXETINE	MYL
02381060	PMS-ATOMOXETINE	PMS
02406004	RIVA-ATOMOXETINE	RIV
02386453	SANDOZ ATOMOXETINE	SDZ
02262843	STRATTERA	LIL
02314592	TEVA-ATOMOXETINE	TEV

80MG CAPSULE

02318075	APO-ATOMOXETINE	APX
02358247	ATOMOXETINE	AAP
02378973	MYLAN-ATOMOXETINE	MYL
02404664	PMS-ATOMOXETINE	PMS
02422824	RIVA-ATOMOXETINE	RIV
02386461	SANDOZ ATOMOXETINE	SDZ
02279347	STRATTERA	LIL
02362511	TEVA-ATOMOXETINE	TEV

100MG CAPSULE

02318083	APO-ATOMOXETINE	APX
02358255	ATOMOXETINE	AAP
02378981	MYLAN-ATOMOXETINE	MYL
02404672	PMS-ATOMOXETINE	PMS
02422832	RIVA-ATOMOXETINE	RIV
02386488	SANDOZ ATOMOXETINE	SDZ
02279355	STRATTERA	LIL
02362538	TEVA-ATOMOXETINE	TEV

BETAHISTINE HYDROCHLORIDE

8MG TABLET

02449145	AURO-BETAHISTINE	AUR
02280183	TEVA-BETAHISTINE	TEV

16MG TABLET

02374757	ACT BETAHISTINE	ACG
02449153	AURO-BETAHISTINE	AUR
02330210	PMS-BETAHISTINE	PMS
02243878	SERC	BGP
02280191	TEVA-BETAHISTINE	TEV

24MG TABLET

02374765	ACT BETAHISTINE	ACG
02449161	AURO-BETAHISTINE	AUR
02330237	PMS-BETAHISTINE	PMS

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

BETAHISTINE HYDROCHLORIDE

24MG TABLET

02247998	SERC	BGP
02280205	TEVA-BETAHISTINE	TEV

TETRABENAZINE

25MG TABLET

02407590	APO-TETRABENAZINE	APX
02199270	NITOMAN	VAE
02402424	PMS-TETRABENAZINE	PMS
02410338	TETRABENAZINE	RAX

32:00 CONTRACEPTIVES (NON-ORAL)

32:00.00 CONTRACEPTIVES (NON-ORAL)

CONDOM

DEVICE

99400527	CONDOM, LATEX, LUBRICATED	UNK
99400485	CONDOM, LATEX, LUBRICATED, NONOXYNOL	UNK
99400486	CONDOM, LATEX, NON-LUBRICATED	UNK
99400786	CONDOM, NON-LATEX, LUBRICATED	UNK

CONTRACEPTIVE DEVICE

DEVICE

00970905	CAYA CONTOURED DIAPHRAGM	TSN

INTRAUTERINE DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 12 months.

DEVICE

00970328	FLEXI-T +300 IUD	TSN
00970336	FLEXI-T +380 IUD	TSN
98099999	FLEXI-TD	TSN
99401085	LIBERTE UT380 SHORT IUD	MSF
99401086	LIBERTE UT380 STANDARD IUD	MSF
00970379	MONA LISA 10	SEA
00970387	MONA LISA 5	SEA
00970395	MONA LISA N	SEA
99400482	NOVA-T	BEX

36:00 DIAGNOSTIC AGENTS (DX)

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

ACCU-CHEK ADVANTAGE STRIP

09853626	ACCU-CHEK ADVANTAGE	ROD
97799824	ACCU-CHEK ADVANTAGE	ROD

ACCU-CHEK AVIVA STRIP

09857178	ACCU-CHEK AVIVA	ROD
97799814	ACCU-CHEK AVIVA	ROD

ACCU-CHEK COMPACT STRIP

09854282	ACCU-CHEK COMPACT	ROD
97799962	ACCU-CHEK COMPACT	ROD

ACCU-CHEK MOBILE STRIP

09857452	ACCU-CHEK MOBILE BG	ROD
97799497	ACCU-CHEK MOBILE CASSETT	ROD

ACCUTREND STRIP

09853162	ACCUTREND	ROD
97799959	ACCUTREND	ROD

ASCENSIA BREEZE 2 STRIP

97799748	ASCENSIA BREEZE 2	BAY
09857293	BREEZE 2 BG (ON)	BAY

ASCENSIA CONTOUR STRIP

97799702	ASCENCIA CONTOUR	BAY
09857127	CONTOUR BG (ON)	BAY

BG STAR STRIP

97799465	BG STAR	SAC
09857422	BG STAR (ON)	SAC

CONTOUR NEXT STRIP

97799459	CONTOUR NEXT	BAY
09857453	CONTOUR NEXT (ON)	BAY

EZ HEALTH STRIP

09857357	EZ HEALTH ORACLE	TRE
97799564	EZ HEALTH ORACLE	TRE

FREESTYLE STRIP

97799829	FREESTYLE	ABB
09857141	FREESTYLE (ON)	ABB

FREESTYLE LITE STRIP

97799597	FREESTYLE LITE	ABB
09857297	FREESTYLE LITE (ON)	ABB

FREESTYLE PRECISION STRIP

97799346	FREESTYLE PRECISION	ABB
09857502	FREESTYLE PRECISION (ON)	ABB

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:

- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

GE200 STRIP

97799373	GE200	AUC
09857525	GE200 (ON)	AUC

ITEST STRIP

09857348	ITEST	AUC
97799692	ITEST	AUC

MEDI+SURE STRIP

97799403	MEDI+SURE	MEC
09857432	MEDI+SURE (ON)	MEC

NOVA MAX STRIP

09857313	NOVA MAX	NCA

ONE TOUCH ULTRA STRIP

09854290	ONE TOUCH ULTRA	JAJ
97799985	ONE TOUCH ULTRA	JAJ

ONE TOUCH VERIO STRIP

97799475	ONETOUCH VERIO	JAJ
09857392	ONETOUCH VERIO (ON)	JAJ

PRECISION XTRA STRIP

09854070	PRECISION XTRA	ABB
97799840	PRECISION XTRA	AUC

SIDEKICK STRIP

97799601	SIDEKICK	HOD

SPIRIT STRIP

97799291	FIRST CANHEALTH SPIRIT	ARA
09857547	SPIRIT TEST STRIP (ON)	ARA

SURE STEP STRIP

97799355	SURE STEP	SKY

SURETEST STRIP

09857522	SURETEST (ON)	SKY

TRUETEST STRIP

97799532	TRUETEST	HOD

TRUETRACK STRIP

09857283	TRUE TRACK	AUC
97799602	TRUE TRACK	HOD

36:60.00 DX - THYROID FUNCTION

THYROTROPIN ALFA

0.9MG/ML POWDER FOR SOLUTION

02246016	THYROGEN	GEE

36:88.00 DX - URINE AND FECES CONTENTS

URINE TEST STRIP

STRIP

97799914	DIASTIX	BAY
97799913	KETOSTIX	BAY

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:08.00 ALKALINIZING AGENTS

CITRIC ACID, SODIUM CITRATE

66.8MG & 100MG/ML SOLUTION

00721344	DICITRATE	PMS

SODIUM BICARBONATE

325MG TABLET

00481912	XENEX SODIUM BICARBONATE	XEN

40:10.00 AMMONIA DETOXICANTS

LACTULOSE

ST **667MG/ML SYRUP**

02242814	APO-LACTULOSE	APX
02295881	JAMP-LACTULOSE	JMP
02412268	LACTULOSE	SAN
02247383	PHARMA-LACTULOSE	PMS
00703486	PMS-LACTULOSE	PMS
00854409	RATIO-LACTULOSE	TEV
02331551	TEVA-LACTULOSE	TEV

40:12.00 REPLACEMENT PREPARATIONS

CALCIUM

ST **500MG CAPLET**

80001408	OYSTER SHELL CALCIUM	NUR

ST **5ML LIQUID**

80004123	CARBOCAL	EUR

ST **20MG/ML LIQUID**

80054754	M-CAL	MAN
80006877	WAMPOLE MINERAL CALCIUM	WAM

ST **100MG LIQUID**

80025527	SOLUCAL GREEN APPLE	JMP
80025523	SOLUCAL RASPBERRY	JMP

ST **1005MG/ML LIQUID**

80043628	NU-CAL	ODN

ST **20MG/ML ORAL LIQUID**

80002626	SOLUCAL	JMP

ST **500MG TABLET**

00682039	APOCAL	APX
80017732	CAL-500	PDL
02240240	CALCIUM	PMT
02246040	CALCIUM	JMP
80003658	CALCIUM	WNP
80003773	CALCIUM	TRI
80062015	CALCIUM CARBONATE	SAN
02237352	EUROCAL	EUR
80055526	M-CAL	MAN
00618098	NU-CAL	ODN
00622443	O-CALCIUM	VTH
80001122	PHARMA-CAL	PED
00705373	WAMPOLE CALCIUM	WAM
02239356	WAMPOLE CALCIUM	WAM

ST **500MG TABLET (CHEWABLE)**

80027026	JAMP-CALCIUM CARBONATE	JMP

500MG TABLET (FILM COATED)

80066648	BIOCALCIUM	BMI

40:12.00 REPLACEMENT PREPARATIONS

CALCIUM GLUCONATE,VIT D

ST **25MCG LIQUID**

80068920	SOLUCAL D FORT CITRUS	JMP
80069353	SOLUCAL D FORT GREEN APPLE	JMP

CALCIUM, VITAMIN D

ST **500MG LIQUID**

80025543	SOLUCAL D CITRUS	JMP
80025541	SOLUCAL D RASPBERRY	JMP

ST **500MG & 1,000IU LIQUID**

80025038	SOLUCAL D FORT	JMP

ST **500MG & 400IU LIQUID**

80061575	CALCITE LIQUIDE D 400	RIV
80054755	M-CAL D	MAN
80008126	SOLUCAL D	JMP

ST **500MG& 800IU LIQUID**

80025722	JAMP CALCIUM LACTOGLUCONATE VITAMIN D	JMP

500MG & 1,000IU TABLET

80066093	CALCIUM 500 VITAMINE D1000	UNK
80018540	JAMP CALCIUM CARBONATE VITAMIN D	JMP
80019536	M CALCIUM VITAMINE D	MAN
80050701	M-CAL D	MAN

ST **500MG & 400IU TABLET**

80012594	BIOCAL-D FORTE	BMI
80004963	CALCITE 500 D 400	RIV
80004969	CALCIUM 500 + VIT D 400	TRI
80066082	CALCIUM 500 VITAMINE D400	UNK
80066089	CALCIUM 500 VITAMINE D400	UNK
80002623	CALCIUM VITAMIN D LEMON FLAVOUR	JMP
80017190	CALD 400	PDL
80009628	CALODAN D 400	ODN
02245511	CARBOCAL D	EUR
80002901	CARBOCAL D	EUR
99100832	JAMP-CALCIUM + VITAMIN D	JMP
80002122	J-CAL+D	JMP
80025360	J-CAL+D	JMP
80009412	M-CAL	MAN
80013329	M-CAL D	MAN
80002703	NU-CAL D	ODN
80020974	OPUS CAL D	OPU
80065914	RIVA-CAL D	RIV
80006794	WAMPOLE CALCIUM VITAMIN D	WAM

ST **500MG & 800IU TABLET**

80019533	M CALCIUM VITAMINE D	MAN

ST **600MG & 400IU TABLET**

80021716	CALCIUM +VIT D	WAM

ST **500MG & 1,000IU TABLET (CHEWABLE)**

80029083	JAMP CALCIUM CITRATE VITAMIN D	JMP
80027787	JAMP-CALCIUM VITAMIN D	JMP

500MG & 400IU TABLET (FILM COATED)

80066647	BIOCALCIUMD	BMI

40:12.00 REPLACEMENT PREPARATIONS

ELECTROLYTES

ST **MISCELLANEOUS**

80023410	HYDRALYTE ELECTROLYTE	HYD

ST **3.56G & 300MG & 470MG & 530MG POWDER**

01931563	GASTROLYTE REGULAR	SAC

ST **POWDER FOR SOLUTION**

80027403	JAMP REHYDRALYTE	JMP

ST **2910MG POWDER FOR SOLUTION**

80026860	HYDRALYTE ELECTROLYTE	HYD

ST **0.856MG/ML SOLUTION**

80026861	HYDRALYTE ELECTROLYTE	HYD

ST **25MG & 2.2MG & 2.2MG & 0.9MG/ML SOLUTION**

00630365	PEDIALYTE	ABB
02219883	PEDIATRIC ELECTROLYTE	PMS

MAGNESIUM

100MG TABLET

80041590	JAMP-MAGNESIUM	JMP
02068400	MAGNESIUM	JAM

MAGNESIUM GLUCOHEPTONATE

ST **25MG LIQUID**

80009357	MAGNESIUM	JMP

ST **100MG/ML ORAL LIQUID**

80004109	MAGNESIUM-ODAN	ODN
00026697	ROUGIER-MAGNESIUM	TEV

MAGNESIUM GLUCONATE

ST **500MG TABLET**

80009539	JAMP-MAGNESIUM	JMP
00555126	MAGLUCATE	PED

POTASSIUM CHLORIDE

ST **600MG CAPSULE**

80062704	JAMP POTASSIUM CHLORIDE ER	JMP

ST **8MMOL CAPSULE (LONG ACTING)**

02244068	RIVA-K 8	RIV

ST **600MG CAPSULE (LONG ACTING)**

02042304	MICRO K	PAL

ST **1,500MG LIQUID**

80024360	K-10	GSK

ST **1.33MEQ/ML ORAL LIQUID**

02238604	PMS-POTASSIUM	PMS

ST **1,500MG ORAL LIQUID**

80024835	JAMP-POTASSIUM CHLORIDE	JMP

ST **8MMOL TABLET**

80008214	ODAN K8	ODN

ST **20MMOL TABLET**

80013007	JAMP K	JMP

ST **25MEQ TABLET**

80033602	JAMP-K EFFERVESCENT	JMP

ST **25MEQ TABLET (EFFERVESCENT)**

02085992	K LYTE	WPC

ST **25MMOL TABLET (EFFERVESCENT)**

80011428	EURO K	EUR

20MEQ TABLET (FILM COATED), EXTENDED RELEASE

80071412	MK20 SOLUBLE	MAN

40:12.00 REPLACEMENT PREPARATIONS

POTASSIUM CHLORIDE

ST **8MMOL TABLET (LONG ACTING)**

00602884	APO-K	APX
02246734	EURO K	EUR
80013005	JAMP-K 8	JMP
80035346	MK 8	MAN

ST **10MMOL TABLET (LONG ACTING)**

80026332	MK 10	MAN

ST **20MMOL TABLET (LONG ACTING)**

80026265	BIO K-20 POTASSIUM	BMI
02242261	EURO K	EUR
80004415	ODAN K20	ODN
02243975	RIVA-K 20	RIV

ST **600MG TABLET (LONG ACTING)**

80040226	SLOW-K	NVR

ST **780MG TABLET (LONG ACTING)**

80025624	MK 20	MAN

ST **780MG TABLET (TIME RELEASE)**

80040412	K20 POTASSIUM	UNK

ST **1,500MG TABLET (TIME RELEASE)**

80040416	PHARMA-K20	PMS
80053887	PRO-K 20	PDL

SODIUM CHLORIDE

0.9% INJECTION

99002329	SODIUM CHLORIDE (SMALL VOL.)	UNK

0.9% SOLUTION

00037818	BACTERIOSTATIC SODIUM CHLORIDE	PFI
00037796	SODIUM CHLORIDE	PFI
00060208	SODIUM CHLORIDE	BAX
00402249	SODIUM CHLORIDE	OMG
02150204	SODIUM CHLORIDE	OMG

40:18.00 ION-REMOVING AGENTS

SODIUM POLYSTYRENE SULFONATE

ORAL LIQUID

01902776	KAYEXALATE	SAC

40:18.18 POTASSIUM - REMOVING AGENTS

CALCIUM POLYSTYRENE SULFONATE

1G POWDER FOR SOLUTION

02017741	RESONIUM CALCIUM	SAC

SODIUM POLYSTYRENE SULFONATE

1G POWDER

02026961	KAYEXALATE	SAC
00765252	K-EXIT	OMG
00755338	SOLYSTAT	PED

250MG/ML SUSPENSION

00769533	SOLYSTAT	PED
00769541	SOLYSTAT	PED

40:18.19 PHOSPHATE - REMOVING AGENTS

LANTHANUM CARBONATE HYDRATE

Limited use benefit (prior approval required).

For patients with elevated phosphate levels OR elevated phosphate X calcium product despite dietary restriction of phosphate and use of calcium-based phosphate binders (short term elevations should be managed with aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

250MG TABLET (CHEWABLE)

02287145	FOSRENOL	SHI

500MG TABLET (CHEWABLE)

02287153	FOSRENOL	SHI

750MG TABLET (CHEWABLE)

02287161	FOSRENOL	SHI

1000MG TABLET (CHEWABLE)

02287188	FOSRENOL	SHI

SEVELAMER HYDROCHLORIDE

Limited use benefit (prior approval required).

For patients with elevated phosphate levels OR elevated phosphate X calcium product despite dietary restriction of phosphate and use of calcium-based phosphate binders (short term elevations should be managed with aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

800MG TABLET

02244310	RENAGEL	SAC

40:20.00 CALORIC AGENTS

LEVOCARNITINE

Limited use benefit (prior approval required).

For treatment of carnitine deficiency.

100MG/ML SOLUTION

02144336	CARNITOR	UNK

200MG/ML SOLUTION

02144344	CARNITOR	UNK

330MG TABLET

02144328	CARNITOR	UNK

40:28.08 LOOP DIURETICS

ETHACRYNIC ACID

ST **25MG TABLET**

02258528	EDECRIN	VAE

40:28.08 LOOP DIURETICS

FUROSEMIDE

ST **10MG/ML SOLUTION**

02224720	LASIX	SAC

ST **20MG TABLET**

00396788	APO FUROSEMIDE	APX
02247371	BIO-FUROSEMIDE	BMI
00496723	FUROSEMIDE	PDL
02351420	FUROSEMIDE	SAN
02247493	PMS-FUROSEMIDE	PMS
00337730	TEVA-FUROSEMIDE	TEV

ST **40MG TABLET**

00362166	APO FUROSEMIDE	APX
02247372	BIO-FUROSEMIDE	BMI
00397792	FUROSEMIDE	PDL
02351439	FUROSEMIDE	SAN
02247494	PMS-FUROSEMIDE	PMS
00337749	TEVA-FUROSEMIDE	TEV

ST **80MG TABLET**

00707570	APO FUROSEMIDE	APX
00667080	FUROSEMIDE	PDL
02351447	FUROSEMIDE	SAN
00765953	TEVA-FUROSEMIDE	TEV

ST **500MG TABLET**

02224755	LASIX SPECIAL	SAC

40:28.16 POTASSIUM SPARING DIURETICS

AMILORIDE

ST **5MG TABLET**

02249510	MIDAMOR	AAP

AMILORIDE, HYDROCHLOROTHIAZIDE

ST **5MG & 50MG TABLET**

00870943	AMI-HYDRO	PDL
00784400	APO-AMILZIDE	APX
01937219	NOVAMILOR	TEV

TRIAMTERENE, HYDROCHLOROTHIAZIDE

ST **50MG & 25MG TABLET**

00441775	APO TRIAZIDE	APX
00519367	PRO-TRIAZIDE	PDL
00532657	TEVA-TRIAMTERENE/HCTZ	TEV

40:28.20 TIAZIDE DIURETICS

HYDROCHLOROTHIAZIDE

ST **12.5MG TABLET**

02327856	APO-HYDRO	APX
02274086	PMS-HYDROCHLOROTHIAZIDE	PMS

ST **25MG TABLET**

00326844	APO HYDRO	APX
02247170	BIO-HYDROCHLOROTHIAZIDE	BMI
00341975	HYDROCHLOROTHIAZIDE	PDL
02360594	HYDROCHLOROTHIAZIDE	SAN
02247386	PMS-HYDROCHLOROTHIAZIDE	PMS
00021474	TEVA-HYDROCHLOROTHIAZIDE	TEV

ST **50MG TABLET**

00312800	APO HYDRO	APX
02247171	BIO-HYDROCHLOROTHIAZIDE	BMI

40:28.20 TIAZIDE DIURETICS

HYDROCHLOROTHIAZIDE

ST **50MG TABLET**

02360608	HYDROCHLOROTHIAZIDE	SAN
02247387	PMS-HYDROCHLOROTHIAZIDE	PMS
00021482	TEVA-HYDROCHLOROTHIAZIDE	TEV

ST **100MG TABLET**

00644552	APO HYDRO	APX

ST **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503000	HYDROCHLOROTHIAZIDE ORAL LIQUID	UNK

SPIRONOLACTONE, HYDROCHLOROTHIAZIDE

ST **25MG & 25MG TABLET**

00180408	ALDACTAZIDE	PFI
00613231	TEVA-SPIRONOLACTONE/HCTZ	TEV

ST **50MG & 50MG TABLET**

00594377	ALDACTAZIDE	PFI
00657182	TEVA-SPIRONOLACTONE/HCTZ	TEV

40:28.24 THIAZIDE LIKE DIURETICS

CHLORTHALIDONE

ST **50MG TABLET**

00360279	CHLORTHALIDONE	AAP

ST **100MG TABLET**

00360287	APO CHLORTHALIDONE	APX

INDAPAMIDE

ST **1.25MG TABLET**

02245246	APO-INDAPAMIDE	APX
02239913	DOM-INDAPAMIDE	DPC
02373904	JAMP-INDAPAMIDE	JMP
02179709	LOZIDE	SEV
02240067	MYLAN-INDAPAMIDE	MYL
02239619	PMS-INDAPAMIDE	PMS
02312530	PRO-INDAPAMIDE	PDL
02247245	RIVA-INDAPAMIDE	RIV

ST **2.5MG TABLET**

02223678	APO-INDAPAMIDE	APX
02239917	DOM-INDAPAMIDE	DPC
02373912	JAMP-INDAPAMIDE	JMP
00564966	LOZIDE	SEV
02153483	MYLAN-INDAPAMIDE	MYL
02239620	PMS-INDAPAMIDE	PMS
02312549	PRO-INDAPAMIDE	PDL
02242125	RIVA-INDAPAMIDE	RIV
02231184	TEVA-INDAPAMIDE	TEV

METOLAZONE

ST **2.5MG TABLET**

00888400	ZAROXOLYN	SAC

40:36.00 IRRIGATING SOLUTIONS

SODIUM CHLORIDE

0.9% SOLUTION

00801267	SODIUM CHLORIDE	UNK
02058235	SODIUM CHLORIDE	RIT

40:40.00 URICOSURIC AGENTS

SULFINPYRAZONE

200MG TABLET

00441767	SULFINPYRAZONE	AAP

40:50.00 IRRIGATING SOLUTIONS

WATER

100% SOLUTION

00038202	BACTERIOSTATIC WATER	HOS
00402257	STERILE WATER	OMG
02142546	STERILE WATER	PFI

48:00 RESPIRATORY TRACT AGENTS

48:02.00 ANTIFIBROTIC AGENTS

NINTEDANIB ESILATE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 week allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

100MG CAPSULE

02443066	OFEV	BOE

150MG CAPSULE

02443074	OFEV	BOE

48:02.00 ANTIFIBROTIC AGENTS

PIRFENIDONE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 weeks allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

267MG CAPSULE

02393751	ESBRIET	HLR

48:10.24 LEUKOTRIENE MODIFIERS

MONTELUKAST SODIUM

Limited use benefit (prior approval required).

For treatment of:
- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **4MG GRANULES**

02358611	SANDOZ MONTELUKAST	SDZ
02247997	SINGULAIR	FRS

ST **10MG TABLET**

02374609	APO-MONTELUKAST	APX
02401274	AURO-MONTELUKAST	AUR
02376695	DOM-MONTELUKAST	DPC
02391422	JAMP-MONTELUKAST	JMP
02399997	MAR-MONTELUKAST	MAR
02408643	MINT-MONTELUKAST	MIN
02379333	MONTELUKAST	SAN
02379856	MONTELUKAST	PDL

48:10.24 LEUKOTRIENE MODIFIERS

MONTELUKAST SODIUM

Limited use benefit (prior approval required).

For treatment of:
- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **10MG TABLET**

02382474	MONTELUKAST	SIV
02379236	MONTELUKAST SODIUM	ACC
02368226	MYLAN-MONTELUKAST	MYL
02373947	PMS-MONTELUKAST	PMS
02389517	RAN-MONTELUKAST	RBY
02398826	RIVA-MONTELUKAST	RIV
02328593	SANDOZ MONTELUKAST	SDZ
02238217	SINGULAIR	FRS
02355523	TEVA-MONTELUKAST	TEV

4MG TABLET (CHEWABLE)

02377608	APO-MONTELUKAST	APX
02422867	AURO-MONTELUKAST	AUR
02442353	JAMP-MONTELUKAST	JMP
02399865	MAR-MONTELUKAST	MAR
02408627	MINT-MONTELUKAST	MIN
02379317	MONTELUKAST	SAN
02379821	MONTELUKAST	PDL
02382458	MONTELUKAST	SIV
02354977	PMS-MONTELUKAST	PMS
02402793	RAN-MONTELUKAST	RBY
02330385	SANDOZ MONTELUKAST	SDZ
02243602	SINGULAIR	FRS
02355507	TEVA-MONTELUKAST	TEV

ST **5MG TABLET (CHEWABLE)**

02377616	APO-MONTELUKAST	APX
02422875	AURO-MONTELUKAST	AUR
02442361	JAMP-MONTELUKAST	JMP
02399873	MAR-MONTELUKAST	MAR
02408635	MINT-MONTELUKAST	MIN
02379325	MONTELUKAST	SAN
02379848	MONTELUKAST	PDL
02382466	MONTELUKAST	SIV
02380757	MYLAN-MONTELUKAST	MYL
02354985	PMS-MONTELUKAST	PMS
02402807	RAN-MONTELUKAST	RBY
02330393	SANDOZ MONTELUKAST	SDZ
02238216	SINGULAIR	FRS
02355515	TEVA-MONTELUKAST	TEV

ZAFIRLUKAST

Limited use benefit (prior approval required).

For treatment of asthma when used in patients on concurrent steroid therapy.

For asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **20MG TABLET**

02236606	ACCOLATE	AZC

48:10.32 MAST CELL STABILIZERS

CROMOLYN SODIUM

100MG CAPSULE

00500895	NALCROM	SAC

2% NASAL SPRAY

02231390	APO-CROMOLYN	APX
01950541	RHINARIS-CS	PED

10MG/ML SOLUTION

02046113	PMS-SODIUM CROMOGLYCATE	PMS

48:48.00 VASODILATING AGENTS

BOSENTAN MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice daily

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND
- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

ST **125MG TABLET**

02399210	APO-BOSENTAN	APX

48:92.00 MISCELLANEOUS RESPIRATORY TRACT AGENTS

OMALIZUMAB

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections over a 24 week period).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with H1 antihistamines; AND
Prescriber is experienced in the treatment of CIU (Allergist, Dermatologist, Immunologist, OR other authorized prescriber experienced in the treatment of CIU).

Treatment cessation could be considered for patients who experience complete symptom control (UAS-7 = 0) for at least 12 consecutive weeks at the end of a 24-week treatment period.

Renewal coverage is provided for 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections/24 weeks).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU);
AND
Patient stopped omalizumab after achieving complete symptom control (UAS-7 = 0) for at least 12 weeks while on treatment, but has experienced symptom relapse; OR
Patient achieved complete symptom control, but for a period of less than 12 consecutive weeks; OR
Patient achieved a partial response to treatment, defined as a ≥ 9.5-point reduction in baseline urticaria activity score over 7 days (UAS-7).

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation may be considered should CIU symptoms reappear.

150MG POWDER FOR SOLUTION

02260565	XOLAIR	NVR

52:00 EYE, EAR, NOSE AND THROAT (EENT)

52:02.00 EENT - ANTIALLERGIC AGENTS

CROMOLYN SODIUM

2% OPHTHALMIC SOLUTION

02009277	CROMOLYN	PED
02230621	OPTICROM	ALL

LEVOCABASTINE HYDROCHLORIDE

0.05% NASAL SPRAY

02020017	LIVOSTIN	JSO

LODOXAMIDE TROMETHAMINE

0.1% SOLUTION

00893560	ALOMIDE	NVR

NEDOCROMIL SODIUM

2% LIQUID

02241407	ALOCRIL	ALL

OLOPATADINE HYDROCHLORIDE

0.1% OPHTHALMIC SOLUTION

02403986	ACT OLOPATADINE	ACG
02305054	APO-OLOPATADINE	APX
02422727	MINT-OLOPATADINE	MIN
02233143	PATANOL	NVR
02358913	SANDOZ OLOPATADINE	SDZ

0.2% OPHTHALMIC SOLUTION

02404095	ACT OLOPATADINE	ACG
02402823	APO-OLOPATADINE	APX
02420171	SANDOZ OLOPATADINE	SDZ

0.1% SOLUTION

02458411	JAMP-OLOPATADINE	JMP

52:04.04 EENT - ANTIBACTERIALS

CHLORAMPHENICOL

1% OINTMENT

02026260	CHLORAMPHENICOL	UNK

0.5% SOLUTION

02023857	CHLORAMPHENICOL	UNK

CIPROFLOXACIN HYDROCHLORIDE

0.3% OINTMENT

02200864	CILOXAN	NVR

0.3% SOLUTION

02263130	APO-CIPROFLOX	APX
01945270	CILOXAN	NVR
02387131	SANDOZ CIPROFLOXACIN	SDZ

CIPROFLOXACIN HYDROCHLORIDE, DEXAMETHASONE

0.3%/0.1% SUSPENSION

02252716	CIPRODEX	NVR

ERYTHROMYCIN

5MG OINTMENT

00641324	ODAN-ERYTHROMYCIN	ODN

5MG/G OINTMENT

02326663	ERYTHROMYCIN	STG

52:04.04 EENT - ANTIBACTERIALS

ERYTHROMYCIN

5MG/G OINTMENT

01912755	PDP-ERYTHROMYCIN	PED

FRAMYCETIN SULFATE

0.5% DROP

02224887	SOFRAMYCIN EYE	ERF

0.5% OINTMENT

02224895	SOFRAMYCIN STERILE EYE	ERF

GATIFLOXACIN

0.3% SOLUTION

02257270	ZYMAR	ALL

GENTAMICIN SULFATE

0.3% LIQUID

00776521	PMS-GENTAMICIN SULFATE	PMS

0.3% OINTMENT

02023776	GENTAMICIN	UNK

0.3% SOLUTION

02023822	GENTAMICIN	UNK

MOXIFLOXACIN HYDROCHLORIDE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

0.5% SOLUTION

02404656	ACT MOXIFLOXACIN	ACG
02406373	APO-MOXIFLOXACIN	APX
02432218	PMS-MOXIFLOXACIN	PMS
02411520	SANDOZ MOXIFLOXACIN	SDZ
02252260	VIGAMOX	NVR

OFLOXACIN

0.3% SOLUTION

02248398	APO-OFLOXACIN	APX
02143291	OCUFLOX	ALL
02247189	SANDOZ OFLOXACIN	SDZ

POLYMYXIN B SULFATE, BACITRACIN ZINC

500IU & 10,000IU/G OINTMENT

02160889	OPTIMYXIN	SDZ
02239157	POLYSPORIN	JAJ

POLYMYXIN B SULFATE, GRAMICIDIN

0.025MG & 10,000U/ML DROP

00701785	OPTIMYXIN	SDZ
02239156	POLYSPORIN EYE AND EAR	JAJ

POLYMYXIN B SULFATE, TRIMETHOPRIM SULFATE

10,000U & 1MG/ML SOLUTION

02240363	PMS-POLYTRIMETHOPRIM	PMS
02011956	POLYTRIM	ALL
02239234	SANDOZ POLYTRIMETHOPRIM	SDZ

SULFACETAMIDE SODIUM

10% SOLUTION

02023830	SULFACETAMIDE	UNK

52:04.04 EENT - ANTIBACTERIALS

TOBRAMYCIN

Limited use benefit (prior approval required).

0.3% OINTMENT

00614254	TOBREX	NVR

0.3% SOLUTION

02241755	SANDOZ TOBRAMYCIN	SDZ
00513962	TOBREX	NVR

52:04.20 EENT - ANTIVIRALS

TRIFLURIDINE

1% SOLUTION

00687456	VIROPTIC	VAE

52:04.92 EENT - MISCELLANEOUS ANTI-INFECTIVES

CHLORHEXIDINE GLUCONATE

0.12% MOUTHWASH

02384272	GUM PAROEX	SUS
02240433	PERICHLOR	PMS
02237452	PERIDEX	MAK
02207796	PERIOGARD	CPA

52:08.00

FLUTICASONE PROPIONATE

50MCG SPRAY

02248307	FLONASE ALLERGY RELIEF	GSK

52:08.08 EENT - CORTICOSTEROIDS

BECLOMETHASONE DIPROPIONATE

50MCG/DOSE NASAL SPRAY

02238796	APO-BECLOMETHASONE	APX
02172712	MYLAN-BECLO AQ	MYL
02228300	RIVANASE AQ	RIV

BUDESONIDE

100MCG/DOSE POWDER

02035324	RHINOCORT TURBUHALER	AZC

64MCG/DOSE SPRAY

02241003	MYLAN-BUDESONIDE AQ	MYL
02231923	RHINOCORT AQUA	MCL

100MCG/DOSE SPRAY

02230648	MYLAN-BUDESONIDE AQ	MYL

DEXAMETHASONE

0.1% OINTMENT

00042579	MAXIDEX	NVR

0.1% SUSPENSION

00042560	MAXIDEX	NVR

DEXAMETHASONE PHOSPHATE

0.1% SOLUTION

02023865	DEXAMETHASONE	UNK
00785261	PMS-DEXAMETHASONE	PMS

DEXAMETHASONE, TOBRAMYCIN

0.1% & 0.3% OINTMENT

00778915	TOBRADEX	NVR

52:08.08 EENT - CORTICOSTEROIDS

DEXAMETHASONE, TOBRAMYCIN

0.1% & 0.3% SUSPENSION

00778907	TOBRADEX	NVR

FLUMETHASONE PIVALATE, CLIOQUINOL

0.02% & 1% DROP

00074454	LOCACORTEN VIOFORM	PAL

FLUNISOLIDE

0.25MG/ML PUMP

02239288	APO-FLUNISOLIDE	APX

FLUOROMETHOLONE

0.1% DROP

00247855	FML	ALL

0.1% SUSPENSION

00756784	FLAREX	NVR
00432814	SANDOZ FLUOROMETHOLONE	SDZ

FLUTICASONE FUROATE

100MCG POWDER

02446561	ARNUITY ELLIPTA	GSK

200MCG POWDER

02446588	ARNUITY ELLIPTA	GSK

FLUTICASONE PROPIONATE

50MCG/DOSE SPRAY

02294745	APO-FLUTICASONE	APX
02296071	RATIO-FLUTICASONE	TEV

FRAMYCETIN SULFATE, GRAMICIDIN, DEXAMETHASONE

5MG & 0.05MG/ML & 0.5MG DROP

02224623	SOFRACORT EAR/EYE	SAC

MOMETASONE FUROATE

50MCG SPRAY

02403587	APO-MOMETASONE	APX
02238465	NASONEX	FRS

500MCG/ML SPRAY

02449811	SANDOZ MOMETASONE	SDZ

PREDNISOLONE ACETATE

0.12% DROP

00299405	PRED MILD	ALL

1% SUSPENSION

00301175	PRED FORTE	ALL
00700401	RATIO-PREDNISOLONE	TEV
01916203	SANDOZ PREDNISOLONE	SDZ

PREDNISOLONE ACETATE, SULFACETAMIDE SODIUM

0.2% & 10% DROP

00807788	BLEPHAMIDE	ALL

0.2% & 10% OINTMENT

00307246	BLEPHAMIDE	ALL

0.5% & 10% SUSPENSION

02023814	PREDNISOLONE/SULFACETAMIDE	UNK

52:08.08 EENT - CORTICOSTEROIDS

PREDNISOLONE SODIUM PHOSPHATE

0.5% DROP

02148498	MINIMS PREDNISOLONE	VAE

TRIAMCINOLONE ACETONIDE

55MCG SPRAY

02437635	APO-TRIAMCINOLONE AQ	APX

55MCG/DOSE SPRAY

02213834	NASACORT AQ	SAC

52:08.20 EENT - NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

DICLOFENAC SODIUM

0.1% SOLUTION

01940414	VOLTAREN OPHTHA	NVR

DICLOFENAC SODIUM (TOPICAL)

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:
- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

0.1% SOLUTION

02441020	APO-DICLOFENAC	APX
02454807	SANDOZ DICLOFENAC OPHTHA	SDZ

KETOROLAC TROMETHAMINE

0.45% SOLUTION

02369362	ACUVAIL	ALL

0.5% SOLUTION

01968300	ACULAR	ALL
02245821	APO-KETOROLAC	AAP

NEPAFENAC

0.1% SUSPENSION

02308983	NEVANAC	NVR

0.3% SUSPENSION

02411393	ILEVRO	NVR

52:12.00 EENT - CONTACT LENS SOLUTION

HYDROXYPROPYLMETHYLCELLULOSE

3MG SOLUTION

02231289	GENTEAL	NVR

52:16.00 EENT - LOCAL ANESTHETICS

LIDOCAINE HYDROCHLORIDE

2% LIQUID

00001686	XYLOCAINE VISCOUS	AZC

52:24.00 EENT - MYDRIATICS

ATROPINE SULFATE

1% SOLUTION

02023695	ATROPINE	UNK
00035017	ISOPTO ATROPINE	NVR
02148358	MINIMS ATROPINE	VAE

52:24.00 EENT - MYDRIATICS

CYCLOPENTOLATE HYDROCHLORIDE

0.5% DROP

02148331	MINIMS CYCLOPENTOLATE	VAE

1% DROP

00252506	CYCLOGYL	NVR
02023644	CYCLOPENTOLATE	UNK
02148382	MINIMS CYCLOPENTOLATE	VAE

DIPIVEFRIN HYDROCHLORIDE

0.1% LIQUID

02242232	APO-DIPIVEFRIN	APX

PHENYLEPHRINE HYDROCHLORIDE

2.5% DROP

02148447	MINIMS PHENYLEPHRINE	VAE
00465763	MYDFRIN	NVR
02027100	PHENYLEPHRINE	UNK

10% DROP

02148455	MINIMS PHENYLEPHRINE	VAE

TROPICAMIDE

0.5% SOLUTION

00000981	MYDRIACYL	NVR

1% SOLUTION

00001007	MYDRIACYL	NVR

52:28.00 EENT - MOUTHWASHES AND GARGLES

BENZYDAMINE HYDROCHLORIDE

Limited use benefit (prior approval required).

- For the treatment of radiation mucositis and oral ulcerative complications of chemotherapy.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02239044	APO-BENZYDAMINE	APX
02229777	PHARIXIA	PED
02239537	PMS-BENZYDAMINE	PMS

52:32.00 EENT - VASOCONSTRICTORS

EPINEPHRINE

1MG/ML SOLUTION

00155365	ADRENALIN	ERF

NAPHAZOLINE HYDROCHLORIDE

0.1% DROP

00001147	ALBALON	ALL
00390283	NAPHCON FORTE	ALC

52:40.04 EENT - ALPHA-ADRENERGIC AGONISTS

BRIMONIDINE TARTRATE

0.15% SOLUTION

02248151	ALPHAGAN P	ALL
02301334	BRIMONIDINE P	AAP

0.2% SOLUTION

02236876	ALPHAGAN	ALL
02260077	APO-BRIMONIDINE	APX

52:40.04 EENT - ALPHA-ADRENERGIC AGONISTS

BRIMONIDINE TARTRATE

0.2% SOLUTION

02246284	PMS-BRIMONIDINE	PMS
02243026	RATIO-BRIMONIDINE	TEV
02305429	SANDOZ BRIMONIDINE	SDZ

TIMOLOL MALEATE, BRIMONIDINE TARTRATE

0.2% & 0.5% SOLUTION

02248347	COMBIGAN	ALL

52:40.08 EENT - BETA-ADRENERGIC BLOCKING AGENTS

BETAXOLOL HYDROCHLORIDE

0.25% OPHTHALMIC SOLUTION

01908448	BETOPTIC S	NVR

LEVOBUNOLOL HYDROCHLORIDE

0.25% OPHTHALMIC SOLUTION

02241575	APO-LEVOBUNOLOL	APX
02031159	RATIO-LEVOBUNOLOL	TEV

0.5% OPHTHALMIC SOLUTION

00637661	BETAGAN	ALL

TIMOLOL MALEATE

0.25% OPHTHALMIC GEL SOLUTION

02242275	TIMOLOL MALEATE-EX	SDZ

0.5% OPHTHALMIC GEL SOLUTION

02290812	APO-TIMOP	APX
02242276	TIMOLOL MALEATE-EX	SDZ
00451207	TIMOPTIC	PFR

0.25% OPHTHALMIC SOLUTION

00755826	APO-TIMOP	APX
02238770	DOM-TIMOLOL	DPC
02083353	PMS-TIMOLOL	PMS

0.5% OPHTHALMIC SOLUTION

00755834	APO-TIMOP	APX
02238771	DOM-TIMOLOL	DPC
02447800	JAMP-TIMOLOL	JMP
02083345	PMS-TIMOLOL	PMS
02166720	SANDOZ TIMOLOL	SDZ

0.25% SOLUTION (LONG ACTING)

02171880	TIMOPTIC-XE	PFR

0.5% SOLUTION (LONG ACTING)

02171899	TIMOPTIC-XE	PFR

52:40.12 EENT - CARBONIC ANHYDRASE INHIBITORS

ACETAZOLAMIDE

250MG TABLET

00545015	ACETAZOLAMIDE	AAP

BRINZOLAMIDE

1% SUSPENSION

02238873	AZOPT	NVR

52:40.12 EENT - CARBONIC ANHYDRASE INHIBITORS

BRINZOLAMIDE, BRIMONIDINE TARTRATE

1% & 0.2% SUSPENSION

02435411	SIMBRINZA	NVR

BRINZOLAMIDE, TIMOLOL MALEATE

1%/0.5% SUSPENSION

02331624	AZARGA	NVR

DORZOLAMIDE HYDROCHLORIDE

2% OPHTHALMIC SOLUTION

02216205	TRUSOPT	FRS
02269090	TRUSOPT	FRS

20MG/ML OPHTHALMIC SOLUTION

02316307	SANDOZ DORZOLAMIDE	SDZ

2% SOLUTION

02459345	RIVA-DORZOLAMIDE	RIV

DORZOLAMIDE HYDROCHLORIDE, TIMOLOL MALEATE

20MG & 5MG OPHTHALMIC SOLUTION

02437686	MED-DORZOLAMIDE-TIMOLOL	GMP

20MG & 5MG/ML OPHTHALMIC SOLUTION

02404389	ACT DORZOTIMOLOL	ACG
02299615	APO-DORZO-TIMOP	APX
02240113	COSOPT	FRS
02442426	PMS-DORZOLAMIDE-TIMOLOL	PMS
02441659	RIVA-DORZOLAMIDE/TIMOLOL	RIV
02344351	SANDOZ DORZOLAMIDE/TIMOLOL	SDZ
02320525	TEVA-DORZOTIMOL	TEV

200MG & 5MG OPHTHALMIC SOLUTION

02443090	MINT-DORZOLAMIDE/TIMOLOL	MIN

METHAZOLAMIDE

50MG TABLET

02245882	METHAZOLAMIDE	AAP

52:40.20 EENT - MIOTICS

CARBACHOL

0.01% OPHTHALMIC SOLUTION

00042544	MIOSTAT	ALC

PILOCARPINE HYDROCHLORIDE

2% OPHTHALMIC SOLUTION

00000868	ISOPTO CARPINE	NVR

4% OPHTHALMIC SOLUTION

00000884	ISOPTO CARPINE	NVR
02023733	PILOCARPINE	UNK

PILOCARPINE NITRATE

2% DROP

02148463	MINIMS PILOCARPINE	VAE

52:40.28 EENT - PROSTAGLANDIN AGENTS

BIMATOPROST

0.01% OPHTHALMIC SOLUTION

02324997	LUMIGAN RC	ALL
09857368	LUMIGAN RC (ON)	ALL

52:40.28 EENT - PROSTAGLANDIN AGENTS

BIMATOPROST

0.01% OPHTHALMIC SOLUTION

09857398	LUMIGAN RC (ON)	ALL

0.03% OPHTHALMIC SOLUTION

02429063	VISTITAN	SDZ

LATANOPROST

0.005% SOLUTION

02254786	ACT LATANOPROST	ACG
02296527	APO-LATANOPROST	APX
02373041	GD-LATANOPROST	PFI
02426935	MED-LATANOPROST	GMP
02317125	PMS-LATANOPROST	PMS
02341085	RIVA-LATANOPROST	RIV
02367335	SANDOZ LATANOPROST	SDZ
02231493	XALATAN	PFI

LATANOPROST, TIMOLOL MALEATE

0.005% & 0.5% SOLUTION

02436256	ACT LATANOPROST/TIMOLOL	ACG
02414155	APO-LATANOPROST-TIMOP	APX
02373068	GD-LATANOPROST/TIMOLOL	PFI
02404591	PMS-LATANOPROST-TIMOLOL	PMS
02394685	SANDOZ LATANOPROST/TIMOLOL	SDZ
02246619	XALACOM	PFI

50MCG & 5MG SOLUTION

02459205	RIVA-LATANOPROST/TIMOLOL	RIV

TIMOLOL MALEATE, TRAVOPROST

0.5% & 0.004% SOLUTION

02278251	DUOTRAV PQ	NVR
02413817	SANDOZ TRAVOPROST / TIMOLOL PQ	SDZ

TRAVOPROST

0.004% SOLUTION

02415739	APO-TRAVOPROST Z	APX
02413167	SANDOZ TRAVOPROST	SDZ
02412063	TEVA-TRAVOPROST Z	TEV
02318008	TRAVATAN Z	NVR

52:92.00 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

Limited use benefit (prior approval required).

For the treatment of:
Diabetic Macular Edema (DME)
Wet Age-Related Macular Degeneration (w-AMD)
Retinal Vein Occlusion (RVO)

(Please refer to Appendix A).

40MG SOLUTION

02415992	EYLEA	BAY

ANETHOLE TRITHIONE

25MG TABLET

02240344	SIALOR	PMS

52:92.00 MISCELLANEOUS EENT DRUGS

APRACLONIDINE HYDROCHLORIDE

0.5% OPHTHALMIC SOLUTION

02076306	IOPIDINE	NVR

DEXTRAN 70, HYDROXYPROPYLMETHYLCELLULOSE

0.1% & 0.3% DROP

01943308	TEARS NATURALE FREE	NVR
00743445	TEARS NATURALE II	NVR

HYDROXYPROPYL CELLULOSE

5MG INSERT

02250624	LACRISERT	ATO

HYDROXYPROPYLMETHYLCELLULOSE

0.5% DROP

00000809	ISOPTO TEARS	NVR

1% DROP

00000817	ISOPTO TEARS	NVR

MACROGOL, PROPYLENE GLYCOL

15% & 20% GEL

02220806	LUBRICATING	PMS
02352699	RHINARIS NASAL	PED
00551805	SECARIS	PED

15% & 20% SPRAY

00732230	LUBRICATING NASAL MIST	PMS
02354551	RHINARIS NASAL MIST	PED

MINERAL OIL, WHITE PETROLATUM

55.5% & 42.5% OINTMENT

00210889	REFRESH LACRI-LUBE	ALL

PETROLATUM, MINERAL OIL

80% & 20% OINTMENT

02125706	SOOTHE NIGHT TIME	BSH

POLYVINYL ALCOHOL

1.4% OPHTHALMIC SOLUTION

02229570	ARTIFICIAL TEARS	PED
00579408	TEARS PLUS	ALL

RANIBIZUMAB

Limited use benefit (prior approval required).

For the treatment of:
Diabetic Macular Edema (DME)
Wet Age-Related Macular Degeneration (w-AMD)
Retinal Vein Occlusion (RVO)
Choroidal Neovascularization secondary to pathologic myopia (mCNV)

(Please refer to Appendix A).

10MG/ML SOLUTION

02296810	LUCENTIS	NVR
02425629	LUCENTIS PFS	NVR

SODIUM CARBOXYMETHYL CELLULOSE

0.5% DROP

02049260	REFRESH PLUS	ALL
02231008	REFRESH TEARS	ALL

52:92.00 MISCELLANEOUS EENT DRUGS

SODIUM CARBOXYMETHYL CELLULOSE

1% DROP

00870153	REFRESH CELLUVISC	ALL

10MG/ML SOLUTION

02244650	REFRESH LIQUIGEL	ALL

SODIUM CHLORIDE

9MG/ML NASAL DROPS

80024901	SALINEX	SDZ

0.7% NASAL SPRAY

00810436	SALINE FROM OTRIVIN	NVC
00857777	SALINE FROM OTRIVIN	NVC

5% OINTMENT

00750816	MURO 128	BSH

5% OPHTHALMIC OINTMENT

80046696	ODAN SODIUM CHLORIDE	ODN

5% OPHTHALMIC SOLUTION

80046737	ODAN-SODIUM CHLORIDE	ODN

5% SOLUTION

00750824	MURO 128	BSH

9MG/ML SPRAY

80024381	SALINEX	SDZ

VERTEPORFIN

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist.

15MG/VIAL POWDER FOR SOLUTION

02242367	VISUDYNE	VAE

WHITE PETROLATUM, LANOLIN, MINERAL OIL

94% & 3% & 3% OINTMENT

02444062	SYSTANE	NVR

56:00 GASTROINTESTINAL DRUGS

56:04.00 ANTACIDS AND ADSORBENTS

BISMUTH SUBSALICYLATE

Limited use benefit (prior approval not required).

Coverage will be limited to 8 tablets a day every 14 days, followed by a 28 day lockout;
OR
Coverage will be limited to 120mL a day every 14 days, followed by a 28 day lockout.

262MG CAPLET

00245730	BISMUTH	JMP

17.6MG/ML LIQUID

02097079	PEPTO BISMOL	PGI

262MG TABLET

02326582	BISMUTH SUBSALICYLATE	UNK
02177994	PEPTO BISMOL	PGI

MAGNESIUM OXIDE

420MG TABLET

00299448	MAGNESIUM OXIDE	VAE

835MG TABLET

00689785	HI POTENCY MAGNESIUM OXIDE	SWS

SODIUM BICARBONATE

325MG TABLET

80072247	SODIUM BICARBONATE	MDS

56:08.00 ANTIDIARRHEA AGENTS

LOPERAMIDE HYDROCHLORIDE

0.2MG/ML SOLUTION

02192667	DIARR-EZE	PMS
02016095	PMS-LOPERAMIDE	PMS

2MG/15ML SOLUTION

02291800	IMODIUM CALMING	MCL

2MG TABLET

02212005	APO-LOPERAMIDE	APX
02229552	DIARR-EZE	PMS
02248994	DIARRHEA RELIEF	PMS
02256452	DIARRHEA RELIEF	VTH
02239535	DOM-LOPERAMIDE	DPC
02183862	IMODIUM	MCL
02225182	LOPERAMIDE	PDL
02228351	PMS-LOPERAMIDE	PMS
02238211	RIVA-LOPERAMIDE	RIV
02132591	TEVA-LOPERAMIDE	TEV

56:12.00 CATHARTICS AND LAXATIVES

BISACODYL

5MG SUPPOSITORY

02410893	BISACODYL	JMP

10MG SUPPOSITORY

02361450	BISACODYL	JMP
00003875	DULCOLAX	BOE
00582883	PMS-BISACODYL	PMS
02241091	THE MAGIC BULLET	DCM

5MG TABLET

00254142	DULCOLAX	BOE
02246039	JAMP-BISACODYL	JMP

56:12.00 CATHARTICS AND LAXATIVES

BISACODYL

5MG TABLET

00587273	PMS-BISACODYL	PMS

5MG TABLET (DELAYED RELEASE)

00545023	APO-BISACODYL	APX
02273411	BISACODYL-ODAN	ODN

CITRIC ACID, MAGNESIUM OXIDE, SODIUM PICOSULFATE

12G & 3.5G & 10MG POWDER FOR SOLUTION

02254794	PICO-SALAX	FEI
02317966	PURG-ODAN	ODN

GLYCERINE

ADULT SUPPOSITORY

00873462	GLYCERIN	TEV
01926039	GLYCERIN	WPC
02020394	GLYCERIN	TEV
80029765	JAMP GLYCERIN	JMP

PEDIATRIC SUPPOSITORY

02020815	GLYCERIN	TEV
01926047	GLYCERIN FOR INFANTS CHILDREN	WPC

MACROGOL, POTASSIUM CHLORIDE, SODIUM BICARBONATE, SODIUM CHLORIDE, SODIUM SULFATE

60G & 750MG & 1.68G & 1.46G & 5.68G/L SOLUTION

00652512	GOLYTELY	BTU
00777838	PEGLYTE	PED

MAGNESIUM CITRATE

5.40% ORAL LIQUID

00262609	CITRO MAG	TEV

50MG/ML ORAL LIQUID

80001809	CITRODAN	ODN

MAGNESIUM HYDROXIDE

80MG/ML LIQUID

02245289	MILK OF MAGNESIA	PMS

80MG/ML ORAL LIQUID

02150646	PHILLIPS MILK OF MAGNESIA	BAY

311MG TABLET

02150638	PHILIPS MAGNESIA	BAY

MINERAL OIL

78% GEL

00608734	LANSOYL	AUP
02186926	LANSOYL SUGAR FREE	AUP

100% LIQUID

01935348	MINERAL OIL (HEAVY)	RBW

POLYETHYLENE GLYCOL 3350

POWDER

09991007	POLYETHYLENE GLYCOL	MDS
09991054	POLYETHYLENE GLYCOL 3350	MDS

100% POWDER FOR SOLUTION

02374137	EMOLAX	JMP
02450070	M-PEG 3350	MAN

56:12.00 CATHARTICS AND LAXATIVES

POLYETHYLENE GLYCOL 3350

ST **1G POWDER FOR SOLUTION**

02317680	LAX-A-DAY	PED
02453193	LAX-A-DAY PHARMA	PMS
02358034	PEG 3350	MDS
02346672	RELAXA	RLI
02318164	RESTORALAX	BAY

POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE

ST **60G & 750MG & 1.68G & 1.46G & 5.68G/L POWDER**

00677442	COLYTE	PED

POLYETHYLENE GLYCOL 3350, SODIUM SULFATE, SODIUM BICARBONATE, SODIUM CHLORIDE, POTASSIUM CHLORIDE, BISACODYL

ST **59.55G & 5.74G & 1.69G & 1.46G & 0.76G & 5MG LIQUID**

02326302	BI-PEGLYTE	PED

PSYLLIUM MUCILLOID

ST **50% POWDER**

00599875	MUCILLIUM	PMS

ST **680MG/G POWDER**

02174812	METAMUCIL FIBRE THERAPY ORIGINAL TEXTURE UNFLAVOURED	PGI
02174790	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR	PGI
02174782	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE ORANGE FLAVOUR (SUGAR-FREE)	PGI
02174804	METAMUCIL FIBRE THERAPY SMOOTH TEXTURE UNFLAVOURED	PGI

SENNOSIDES

ST **1.7MG/ML LIQUID**

80024394	JAMP SENNAQUIL	JMP
00367729	SENOKOT	PFR

ST **1.7MG/ML ORAL LIQUID**

02144379	SENNALAX	PMS
02084651	SENNAPREP	PMS

ST **8.6MG TABLET**

02247389	EURO-SENNA	EUR
80043280	M SENNOSIDES	MAN
80047592	OPUS SENNOSIDES	OPU
01949292	RIVA SENNA	RIV
02237105	SENNA LAXATIVE	VTH
02068109	SENNA SENNOSIDES	PMS
00026158	SENOKOT	PFR

ST **9MG TABLET**

80019511	BIOSENNOSIDES	BMI
80054498	M SENNOSIDES	MAN
00896411	PMS-SENNOSIDES	PMS
80009595	SENNA	JMP
80009182	SENNOSIDES	JMP

56:12.00 CATHARTICS AND LAXATIVES

SENNOSIDES

ST **12MG TABLET**

80055641	M-SENNOSIDES	MAN
00896403	PMS-SENNOSIDES	PMS
80009183	SENNOSIDES	JMP

ST **15MG TABLET**

02226030	EX-LAX CHOCOLATED	NVC

43MG TABLET

80061813	SENNACE	VAN

8.6MG TABLET (FILM COATED)

80064362	SENNA SENNOSIDES NATURALS	UNK

15MG TABLET (FILM COATED)

80054167	SENNOSIDES	UNK

SODIUM PHOSPHATE

ST **180MG & 480MG/ML ORAL LIQUID**

02230399	PMS-PHOSPHATES	PMS

ST **0.9G ORAL SOLUTION**

80000689	PHOSLAX	ODN

ST **60MG & 160MG/ML RECTAL LIQUID**

02096900	ENEMOL SODIUM PHOSPHATE	DPC
00009911	FLEET ENEMA	KIM
00108065	FLEET ENEMA PEDIATRIC	KIM

ST **2.4G SOLUTION**

80034416	JAMP-SODIUM PHOSPHATE	JMP

SORBITOL, SODIUM CITRATE, SODIUM LAURYL SULFOACETATE

ST **90MG & 9MG & 625MG ENEMA**

02063905	MICROLAX	MCL

56:14.00 CHOLELITHOLYTIC AGENTS

URSODIOL

ST **250MG TABLET**

02273497	PMS-URSODIOL	PMS
02238984	URSO	APC
02426900	URSODIOL	GLK

ST **500MG TABLET**

02273500	PMS-URSODIOL	PMS
02245894	URSO DS	APC
02426919	URSODIOL	GLK

ST **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503024	UROSODIOL ORAL LIQUID	UNK

56:16.00 DIGESTANTS

LACTASE

ST **3,000U CAPLET**

02239139	DAIRY DIGESTIVE	VTH

ST **4,500U CAPLET**

02239140	DAIRY DIGESTIVE	VTH

ST **ORAL LIQUID**

99100157	LACTEEZE DROPS	AUP

ST **3 TABLET**

02181304	LACTEEZE	GSC

ST **300MG TABLET**

80070358	JAMPLACTASE ENZYME	JMP

56:16.00 DIGESTANTS

LACTASE

ST **3,000U TABLET**

01951637	DAIRYAID	TAN
02230653	LACTAID	KIM
02017512	LACTOMAX	STE

ST **4,500U TABLET**

02230654	LACTAID EXTRA STRENGTH	KIM
02224909	LACTOMAX EXTRA	STE

ST **9,000U TABLET**

02231507	LACTAID ULTRA	KIM

LIPASE, AMYLASE, PROTEASE

ST **6,000U & 30,000U & 19,000U CAPSULE**

02415194	CREON MINIMICROSPHERES 6	BGP

ST **8,000U & 30,000U & 30,000U CAPSULE**

00263818	COTAZYM	FRS
00502790	COTAZYM ECS 8	FRS

ST **20,000U & 55,000U & 55,000U CAPSULE**

00821373	COTAZYM ECS 20	FRS

ST **4200U & 17500U & 10000U CAPSULE (ENTERIC COATED)**

00789445	PANCREASE MT 4	JSO

ST **10500U & 43750U & 25000U CAPSULE (ENTERIC COATED)**

00789437	PANCREASE MT 10	JSO

ST **16800U & 70000U & 40000U CAPSULE (ENTERIC COATED)**

00789429	PANCREASE MT 16	JSO

ST **5000U & 5100U & 320U GRANULES**

02445158	CREON MINIMICROSPHERES MICRO	BGP

ST **10440U & 56400U & 57100U TABLET**

02230019	VIOKACE	APC

ST **20880U & 113400U & 112500U TABLET**

02241933	VIOKACE	APC

56:20.00 EMETICS

IPECAC

14MG/ML ORAL LIQUID

00378801	IPECAC	XEN

56:22.08 ANTIHISTAMINES

DIMENHYDRINATE

Limited use benefit (prior approval not required).

The NIHB Program implemented a dose coverage limit for DIMENHYDRINATE in June 2017 as part of a strategy to address safety concerns and potential misuse.

The dimenhydrinate dose limit is currently 400 mg per day for a total of 12,000 mg of dimenhydrinate in a 30-day period.

This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms are not included in this limit.

50MG/ML SOLUTION

00392537	DIMENHYDRINATE	SDZ
00013579	GRAVOL	CHU

56:22.08 ANTIHISTAMINES

DIMENHYDRINATE

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The dimenhydrinate dose limit is currently 400 mg per day for a total of 12,000 mg of dimenhydrinate in a 30-day period.

This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms are not included in this limit.

25MG SUPPOSITORY

00783595	GRAVOL	CHU

50MG SUPPOSITORY

00392553	SANDOZ DIMENHYDRINATE	SDZ

100MG SUPPOSITORY

00013609	GRAVOL	CHU

ST **3MG/ML SYRUP**

00230197	GRAVOL	CHU

ST **50MG TABLET**

00363766	APO DIMENHYDRINATE	APX
00013803	GRAVOL	CHU
02245416	JAMP-DIMENHYDRINATE	JMP
02377179	MOTION SICKNESS	APX
00399779	NAUSEATOL	SDZ
00586331	PMS-DIMENHYDRINATE	PMS
00605786	TRAVEL	VTH
00021423	TRAVEL ON	NOP

DOXYLAMINE SUCCINATE, PYRIDOXINE HYDROCHLORIDE

ST **10MG & 10MG TABLET (DELAYED RELEASE)**

00609129	DICLECTIN	DUI

56:22.20 5-HT3 RECEPTOR ANTAGONISTS

GRANISETRON HYDROCHLORIDE

ST **1MG TABLET**

02308894	APO-GRANISETRON	APX
02452359	NAT-GRANISETRON	NPH

ONDANSETRON HYDROCHLORIDE

ST **4MG FILM**

02389983	ONDISSOLVE ODF	TAK

ST **8MG FILM**

02389991	ONDISSOLVE ODF	TAK

ST **0.8MG/ML SOLUTION**

02291967	ONDANSETRON	AAP
02229639	ZOFRAN	NVR

ST **4MG TABLET**

02296349	ACT ONDANSETRON	ACG
02288184	APO-ONDANSETRON	APX
02313685	JAMP-ONDANSETRON	JMP
02371731	MAR-ONDANSETRON	MAR
02305259	MINT-ONDANSETRON	MIN
02297868	MYLAN-ONDANSETRON	MYL
02417839	NAT-ONDANSETRON	NPH
02421402	ONDANSETRON	SAN

56:22.20 5-HT3 RECEPTOR ANTAGONISTS

ONDANSETRON HYDROCHLORIDE

4MG TABLET

02258188	PMS-ONDANSETRON	PMS
02312247	RAN-ONDANSETRON	RBY
02274310	SANDOZ ONDANSETRON	SDZ
02376091	SEPTA-ONDANSETRON	SPT
02264056	TEVA-ONDANSETRON	TEV
02448440	VAN-ONDANSETRON	VAN
02213567	ZOFRAN	NVR

8MG TABLET

02296357	ACT ONDANSETRON	ACG
02288192	APO-ONDANSETRON	APX
02313693	JAMP-ONDANSETRON	JMP
02371758	MAR-ONDANSETRON	MAR
02305267	MINT-ONDANSETRON	MIN
02297876	MYLAN-ONDANSETRON	MYL
02417847	NAT-ONDANSETRON	NPH
02325160	ONDANSETRON	PDL
02421410	ONDANSETRON	SAN
02258196	PMS-ONDANSETRON	PMS
02312255	RAN-ONDANSETRON	RBY
02274329	SANDOZ ONDANSETRON	SDZ
02376105	SEPTA-ONDANSETRON	SPT
02264064	TEVA-ONDANSETRON	TEV
02448467	VAN-ONDANSETRON	VAN
02213575	ZOFRAN	NVR

4MG TABLET (ORALLY DISINTEGRATING)

02444674	SANDOZ ONDANSETRON ODT	SDZ
02239372	ZOFRAN ODT	NVR

8MG TABLET (ORALLY DISINTEGRATING)

02444682	SANDOZ ONDANSETRON ODT	SDZ
02239373	ZOFRAN ODT	NVR

56:22.32 MISCELLANEOUS ANTIEMETICS

APREPITANT

Limited use benefit (prior approval required).

When used in combination with a 5-HT3 antagonist and dexamethasone for the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).

80MG CAPSULE

02298791	EMEND	FRS

125MG CAPSULE

02298805	EMEND	FRS

125MG & 80MG CAPSULE

02298813	EMEND TRI-PACK	FRS

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;
OR
Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

0.25MG CAPSULE

02312263	CESAMET	VAE
02358077	RAN-NABILONE	RBY
02392925	TEVA-NABILONE	TEV

0.5MG CAPSULE

02393581	ACT NABILONE	ACG
02256193	CESAMET	VAE
02380900	PMS-NABILONE	PMS
02358085	RAN-NABILONE	RBY
02384884	TEVA-NABILONE	TEV

1MG CAPSULE

02393603	ACT NABILONE	ACG
00548375	CESAMET	VAE
02380919	PMS-NABILONE	PMS
02358093	RAN-NABILONE	RBY
02384892	TEVA-NABILONE	TEV

56:28.12 HISTAMINE H2-ANTAGONISTS

CIMETIDINE

200MG TABLET

00584215	APO CIMETIDINE	APX
00582409	NOVO-CIMETINE	TEV

300MG TABLET

00487872	APO CIMETIDINE	APX
02231287	DOM-CIMETIDINE	DPC
02227444	MYLAN-CIMETIDINE	MYL
00582417	NOVO-CIMETINE	TEV

400MG TABLET

00600059	APO CIMETIDINE	APX
02231288	DOM-CIMETIDINE	DPC
00603678	NOVO-CIMETINE	TEV

600MG TABLET

00600067	APO CIMETIDINE	APX
02231290	DOM-CIMETIDINE	DPC
00603686	NOVO-CIMETINE	TEV

800MG TABLET

00749494	APO-CIMETIDINE	APX
00663727	NOVO-CIMETINE	TEV

FAMOTIDINE

20MG TABLET

01953842	APO-FAMOTIDINE	APX
02351102	FAMOTIDINE	SAN
02196018	MYLAN-FAMOTIDINE	MYL
02022133	TEVA-FAMOTIDINE	TEV

40MG TABLET

01953834	APO-FAMOTIDINE	APX
02351110	FAMOTIDINE	SAN
02196026	MYLAN-FAMOTIDINE	MYL

56:28.12 HISTAMINE H2-ANTAGONISTS

FAMOTIDINE

40MG TABLET

02022141	TEVA-FAMOTIDINE	TEV

NIZATIDINE

150MG CAPSULE

00778338	AXID	PED
02177714	PMS-NIZATIDINE	PMS

300MG CAPSULE

00778346	AXID	PED
02177722	PMS-NIZATIDINE	PMS

RANITIDINE HYDROCHLORIDE

15MG/ML SOLUTION

02280833	APO-RANITIDINE	APX
02242940	TEVA-RANITIDINE	TEV

150MG TABLET

02248570	ACT RANITIDINE	TEV
00733059	APO-RANITIDINE	APX
02293471	MAXIMUM STRENGTH ACID REDUCER	PMS
02242453	PMS-RANITIDINE	PMS
00740748	RANITIDINE	PDL
02353016	RANITIDINE	SAN
02385953	RANITIDINE	SIV
02336480	RAN-RANITIDINE	RBY
02247814	RIVA-RANITIDINE	RIV
02243229	SANDOZ RANITIDINE	SDZ
00828564	TEVA-RANITIDINE	TEV

300MG TABLET

02248571	ACT RANITIDINE	TEV
00733067	APO-RANITIDINE	APX
02242454	PMS-RANITIDINE	PMS
00740756	RANITIDINE	PDL
02353024	RANITIDINE	SAN
02385961	RANITIDINE	SIV
02336502	RAN-RANITIDINE	RBY
02247815	RIVA-RANITIDINE	RIV
02243230	SANDOZ RANITIDINE	SDZ

56:28.28 PROSTAGLANDINS

MISOPROSTOL

100MCG TABLET

02244022	MISOPROSTOL	AAP

200MCG TABLET

02244023	MISOPROSTOL	AAP

56:28.32 PROTECTANTS

SUCRALFATE

200MG/ML SUSPENSION

02103567	SULCRATE PLUS	APC

1G TABLET

02125250	APO-SUCRALFATE	APX
02100622	SULCRATE	APC
02045702	TEVA-SUCRALFATE	TEV

56:28.36 PROTON-PUMP INHIBITORS

AMOXICILLIN, CLARITHROMYCIN, LANSOPRAZOLE

500MG & 500MG & 30MG KIT

02238525	HP-PAC	TAK

LANSOPRAZOLE

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

15MG CAPSULE (DELAYED RELEASE)

02293811	APO-LANSOPRAZOLE	APX
02357682	LANSOPRAZOLE	SAN
02385767	LANSOPRAZOLE	SIV
02433001	LANSOPRAZOLE	PMS
02353830	MYLAN-LANSOPRAZOLE	MYL
02395258	PMS-LANSOPRAZOLE	PMS
02165503	PREVACID	TAK
02402610	RAN-LANSOPRAZOLE	RBY
02422808	RIVA-LANSOPRAZOLE	RIV
02385643	SANDOZ LANSOPRAZOLE	SDZ
02280515	TEVA-LANSOPRAZOLE	TEV

30MG CAPSULE (DELAYED RELEASE)

02293838	APO-LANSOPRAZOLE	APX
02414775	DOM-LANSOPRAZOLE	DPC
02357690	LANSOPRAZOLE	SAN
02366282	LANSOPRAZOLE	PDL
02410389	LANSOPRAZOLE	SIV
02433028	LANSOPRAZOLE	PMS
02353849	MYLAN-LANSOPRAZOLE	MYL
02395266	PMS-LANSOPRAZOLE	PMS
02165511	PREVACID	TAK
02402629	RAN-LANSOPRAZOLE	RBY
02422816	RIVA-LANSOPRAZOLE	RIV
02280523	TEVA-LANSOPRAZOLE	TEV

30MG TABLET (DELAYED RELEASE)

02385651	SANDOZ LANSOPRAZOLE	SDZ

PDIN FOR EXTEMPORANEOUS MIXTURE

99503010	LANSOPRAZOLE ORAL LIQUID	UNK

LANSOPRAZOLE ODT

Limited use benefit (prior approval required).

Coverage will be limited to 400 tablets/capsules every 180 days.

For children 12 years of age or under who are unable to swallow the capsule formulation; OR
For patients with dysphagia or a feeding tube when the use of the capsule formulation is not possible.

(Please refer to Appendix A).

15MG TABLET (DELAYED RELEASE)

02249464	PREVACID FASTAB	TAK

30MG TABLET (DELAYED RELEASE)

02249472	PREVACID FASTAB	TAK

56:28.36 PROTON-PUMP INHIBITORS

OMEPRAZOLE MAGNESIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

ST **20MG CAPSULE (DELAYED RELEASE)**

02245058	APO-OMEPRAZOLE	APX
00846503	LOSEC	AZC
02329433	MYLAN-OMEPRAZOLE	MYL
02339927	OMEPRAZOLE	PDL
02348691	OMEPRAZOLE	SAN
02385384	OMEPRAZOLE	SIV
02411857	OMEPRAZOLE-20	SIV
02320851	PMS-OMEPRAZOLE	PMS
02403617	RAN-OMEPRAZOLE	RBY
02296446	SANDOZ OMEPRAZOLE	SDZ

ST **20MG TABLET (DELAYED RELEASE)**

02333430	DOM-OMEPRAZOLE DR	DPC
02420198	JAMP-OMEPRAZOLE DR	JMP
02190915	LOSEC	AZC
02439549	NAT-OMEPRAZOLE DR	NPH
02416549	OMEPRAZOLE	ACC
02310260	PMS-OMEPRAZOLE	PMS
02374870	RAN-OMEPRAZOLE	RBY
02260867	RATIO-OMEPRAZOLE	TEV
02402416	RIVA-OMEPRAZOLE DR	RIV
02295415	TEVA-OMEPRAZOLE	TEV
02432404	VAN-OMEPRAZOLE	VAN

PDIN FOR EXTEMPORANEOUS MIXTURE

99503002	OMEPRAZOLE ORAL LIQUID	UNK

PANTOPRAZOLE MAGNESIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

ST **40MG TABLET (DELAYED RELEASE)**

02466147	PANTOPRAZOLE T	SAN

ST **40MG TABLET (ENTERIC COATED)**

02408570	MYLAN-PANTOPRAZOLE T	MYL
02441853	PANTOPRAZOLE MAGNESIUM	UNK
02267233	TECTA	TAK
02440628	TEVA-PANTOPRAZOLE MAGNESIUM	TEV

PANTOPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

ST **40MG TABLET (DELAYED RELEASE)**

02300486	ACT PANTOPRAZOLE	ACG
02292920	APO-PANTOPRAZOLE	APX
02415208	AURO-PANTOPRAZOLE	AUR

56:28.36 PROTON-PUMP INHIBITORS

PANTOPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

ST **40MG TABLET (DELAYED RELEASE)**

02310007	DOM-PANTOPRAZOLE	DPC
02357054	JAMP-PANTOPRAZOLE	JMP
02416565	MAR-PANTOPRAZOLE	MAR
02417448	MINT-PANTOPRAZOLE	MIN
02299585	MYLAN-PANTOPRAZOLE	MYL
02229453	PANTOLOC	TAK
02318695	PANTOPRAZOLE	PDL
02370808	PANTOPRAZOLE	SAN
02431327	PANTOPRAZOLE	RIV
02437945	PANTOPRAZOLE	PMS
02428180	PANTOPRAZOLE-40	SIV
02307871	PMS-PANTOPRAZOLE	PMS
02425378	PRIVA-PANTOPRAZOLE	PHA
02305046	RAN-PANTOPRAZOLE	RBY
02316463	RIVA-PANTOPRAZOLE	RIV
02301083	SANDOZ PANTOPRAZOLE	SDZ
02285487	TEVA-PANTOPRAZOLE	TEV

RABEPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

(Please refer to Appendix A).

ST **10MG TABLET (ENTERIC COATED)**

02345579	APO-RABEPRAZOLE	APX
02408392	MYLAN-RABEPRAZOLE	MYL
02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBY
02330083	RIVA-RABEPRAZOLE EC	RIV
02314177	SANDOZ RABEPRAZOLE	SDZ
02296632	TEVA-RABEPRAZOLE	TEV

ST **20MG TABLET (ENTERIC COATED)**

02345587	APO-RABEPRAZOLE	APX
02320460	DOM-RABEPRAZOLE EC	DPC
02243797	PARIET	JSO
02310813	PMS-RABEPRAZOLE	PMS
02315203	PRO-RABEPRAZOLE	PDL
02385457	RABEPRAZOLE	SIV
02356538	RABEPRAZOLE EC	SAN
02298082	RAN-RABEPRAZOLE	RBY
02330091	RIVA-RABEPRAZOLE	RIV
02314185	SANDOZ RABEPRAZOLE	SDZ
02296640	TEVA-RABEPRAZOLE	TEV

56:32.00 PROKINETIC AGENTS

DOMPERIDONE MALEATE

ST **10MG TABLET**

02103613	APO-DOMPERIDONE	APX
02238315	DOM-DOMPERIDONE	DPC
02236857	DOMPERIDONE	PDL
02238341	DOMPERIDONE	SIV
02350440	DOMPERIDONE	SAN
02369206	JAMP-DOMPERIDONE	JMP
02403870	MAR-DOMPERIDONE	MAR
02236466	PMS-DOMPERIDONE	PMS
02268078	RAN-DOMPERIDONE	RBY
01912070	RATIO-DOMPERIDONE	TEV
02157195	TEVA-DOMPERIDONE	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503005	DOMPERIDONE ORAL LIQUID	UNK

METOCLOPRAMIDE HYDROCHLORIDE

ST **1MG/ML SOLUTION**

02230433	METONIA	PED

ST **5MG TABLET**

00842826	APO-METOCLOP	APX
02230431	METONIA	PED

ST **10MG TABLET**

00842834	APO-METOCLOP	APX
02230432	METONIA	PED

56:36.00 ANTI-INFLAMMATORY AGENTS

BETAMETHASONE SODIUM PHOSPHATE

0.05MG/ML ENEMA

02060884	BETNESOL	PAL

HYDROCORTISONE ACETATE

10% AEROSOL

00579335	CORTIFOAM	PAL

100MG/60ML ENEMA

02112736	CORTENEMA	APC

MESALAZINE

500MG SUPPOSITORY

02112760	SALOFALK	APC

1G SUPPOSITORY

02153564	PENTASA	FEI
02242146	SALOFALK	APC

1G/100ML SUSPENSION

02153521	PENTASA	FEI

2G/60G SUSPENSION

02112795	SALOFALK	APC

4G/100ML SUSPENSION

02153556	PENTASA	FEI

4G/60G SUSPENSION

02112809	SALOFALK	APC

ST **500MG TABLET (DELAYED RELEASE)**

02112787	SALOFALK	APC

ST **800MG TABLET (DELAYED RELEASE)**

02267217	ASACOL	WAC

ST **400MG TABLET (ENTERIC COATED)**

01997580	ASACOL	WAC

56:36.00 ANTI-INFLAMMATORY AGENTS

MESALAZINE

ST **400MG TABLET (ENTERIC COATED)**

02171929	TEVA-5 ASA	TEV

ST **500MG TABLET (EXTENDED RELEASE)**

02099683	PENTASA	FEI

ST **1G TABLET (EXTENDED RELEASE)**

02399466	PENTASA	FEI

ST **1.2G TABLET (EXTENDED RELEASE)**

02297558	MEZAVANT	SHI

OLSALAZINE SODIUM

ST **250MG CAPSULE**

02063808	DIPENTUM	APU

56:92.00 MISCELLANEOUS GI DRUGS

PINAVERIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR
In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

50MG CAPSULE

00465240	DICETEL	SPH

50MG TABLET

01950592	DICETEL	BGP

100MG TABLET

02230684	DICETEL	BGP

60:00 GOLD COMPOUNDS

60:00.00 GOLD COMPOUNDS

AURANOFIN

3MG CAPSULE

01916823	RIDAURA	XED

SODIUM AUROTHIOMALATE

10MG/ML SOLUTION

01927620	MYOCHRYSINE	SAC
02245456	SODIUM AUROTHIOMALATE	SDZ

25MG/ML SOLUTION

01927612	MYOCHRYSINE	SAC

50MG/ML SOLUTION

01927604	MYOCHRYSINE	SAC
02245458	SODIUM AUROTHIOMALATE	SDZ

64:00 HEAVY METAL ANTAGONISTS

64:00.00 HEAVY METAL ANTAGONISTS

PENICILLAMINE

250MG CAPSULE

00016055	CUPRIMINE	VAE

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:04.00 ADRENALS

BECLOMETHASONE DIPROPIONATE

50MCG AEROSOL

02242029	QVAR	VAE

100MCG AEROSOL

02242030	QVAR	VAE

BUDESONIDE

3MG CAPSULE (SUSTAINED RELEASE)

02229293	ENTOCORT	TIL

100MCG INHALER

00852074	PULMICORT TURBUHALER	AZC

200MCG INHALER

00851752	PULMICORT TURBUHALER	AZC

400MCG INHALER

00851760	PULMICORT TURBUHALER	AZC

0.125MG/ML SUSPENSION

02229099	PULMICORT NEBUAMP	AZC

0.25MG/ML SUSPENSION

01978918	PULMICORT NEBUAMP	AZC

0.5MG/ML SUSPENSION

01978926	PULMICORT NEBUAMP	AZC

CICLESONIDE

100MG/INHALATION AEROSOL

02285606	ALVESCO	AZC

200MG/INHALATION AEROSOL

02285614	ALVESCO	AZC

CORTISONE ACETATE

25MG TABLET

00280437	CORTISONE	VAE

DEXAMETHASONE

0.1MG/ML LIQUID

01946897	PMS DEXAMETHASONE	PMS

0.5MG TABLET

02261081	APO-DEXAMETHASONE	APX
01964976	PMS DEXAMETHASONE	PMS
02240684	RATIO-DEXAMETHASONE	TEV

0.75MG TABLET

01964968	PMS DEXAMETHASONE	PMS

2MG TABLET

02279363	PMS-DEXAMETHASONE	PMS

4MG TABLET

02250055	APO-DEXAMETHASONE	APX
01964070	PMS DEXAMETHASONE	PMS
02311267	PRO-DEXAMETHASONE	PDL
02240687	RATIO-DEXAMETHASONE	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503007	DEXAMETHASONE ORAL LIQUID	UNK

DEXAMETHASONE PHOSPHATE

4MG/ML LIQUID

00664227	DEXAMETHASONE	SDZ
01977547	DEXAMETHASONE	RAX

68:04.00 ADRENALS

DEXAMETHASONE PHOSPHATE

4MG/ML LIQUID

02204266	DEXAMETHASONE-OMEGA	OMG

10MG/ML LIQUID

00874582	DEXAMETHASONE	SDZ
02204274	DEXAMETHASONE-OMEGA	OMG
00783900	PMS-DEXAMETHASONE	PMS

FLUDROCORTISONE ACETATE

0.1MG TABLET

02086026	FLORINEF	PAL

FLUTICASONE PROPIONATE

50MCG/INHALATION AEROSOL

02244291	FLOVENT HFA	GSK

125MCG/INHALATION AEROSOL

02244292	FLOVENT HFA	GSK

250MCG/INHALATION AEROSOL

02244293	FLOVENT HFA	GSK

100MCG/DOSE POWDER

02237245	FLOVENT DISKUS	GSK

250MCG/DOSE POWDER

02237246	FLOVENT DISKUS	GSK

500MCG/DOSE POWDER

02237247	FLOVENT DISKUS	GSK

HYDROCORTISONE ACETATE

10MG TABLET

00030910	CORTEF	PFI

20MG TABLET

00030929	CORTEF	PFI

METHYLPREDNISOLONE

4MG TABLET

00030988	MEDROL	PFI

16MG TABLET

00036129	MEDROL	PFI

METHYLPREDNISOLONE ACETATE

20MG/ML SUSPENSION

01934325	DEPO-MEDROL	PFI

40MG/ML SUSPENSION

00030759	DEPO-MEDROL	PFI
01934333	DEPO-MEDROL	PFI
02245400	METHYLPREDNISOLONE	SDZ
02245407	METHYLPREDNISOLONE	SDZ

80MG/ML SUSPENSION

00030767	DEPO-MEDROL	PFI
01934341	DEPO-MEDROL	PFI
02245406	METHYLPREDNISOLONE	SDZ
02245408	METHYLPREDNISOLONE	SDZ

MOMETASONE FUROATE

200MCG POWDER

02243595	ASMANEX TWISTHALER	FRS

400MCG POWDER

02243596	ASMANEX TWISTHALER	FRS

68:04.00 ADRENALS

PREDNISOLONE SODIUM PHOSPHATE

1MG/ML SOLUTION

02230619	PEDIAPRED	SAC
02245532	PMS-PREDNISOLONE	PMS

PREDNISONE

1MG TABLET

00598194	APO PREDNISONE	APX
00271373	WINPRED	AAP

5MG TABLET

00312770	APO PREDNISONE	APX
00156876	PREDNISONE	PDL
00021695	TEVA-PREDNISONE	TEV

50MG TABLET

00550957	APO PREDNISONE	APX
00232378	TEVA-PREDNISONE	TEV

PDIN FOR EXTEMPORANEOUS MIXTURE

99503008	PREDNISONE ORAL LIQUID	UNK

TRIAMCINOLONE ACETONIDE

10MG/ML SUSPENSION

01999761	KENALOG-10	BMS
02229540	TRIAMCINOLONE	SDZ

40MG/ML SUSPENSION

01999869	KENALOG-40	BMS
01977563	TRIAMCINOLONE	RAX
02229550	TRIAMCINOLONE	SDZ
09857128	TRIAMCINOLONE	UNK

TRIAMCINOLONE DIACETATE

40MG/ML SUSPENSION

01977555	TRIAMCINOLONE	RAX

68:08.00 ANDROGENS

DANAZOL

50MG CAPSULE

02018144	CYCLOMEN	SAC

100MG CAPSULE

02018152	CYCLOMEN	SAC

200MG CAPSULE

02018160	CYCLOMEN	SAC

TESTOSTERONE CYPIONATE

100MG/ML SOLUTION

00030783	DEPO-TESTOSTERONE	PFI
02246063	TESTOSTERONE CYPIONATE	SDZ

TESTOSTERONE ENANTHATE

200MG/ML SOLUTION

00029246	DELATESTRYL	VAE

TESTOSTERONE UNDECANOATE

40MG CAPSULE

00782327	ANDRIOL	FRS
02322498	PMS-TESTOSTERONE	PMS
02421186	TARO-TESTOSTERONE	TAR

68:12.00 CONTRACEPTIVES

DESOGESTREL, ETHINYL ESTRADIOL

ST **25MCG & 150MCG, 125MCG, 100MCG TABLET**

02272903	LINESSA 21	ASP
02257238	LINESSA 28	ASP

ETHINYL ESTRADIOL, DESOGESTREL

ST **30MCG & 150MCG TABLET**

02317192	APRI 21	TEV
02317206	APRI 28	TEV
02396491	FREYA 21	MYL
02396610	FREYA 28	MYL
02042487	MARVELON 21	FRS
02042479	MARVELON 28	FRS
02410249	MIRVALA 21	APX
02410257	MIRVALA 28	APX
02420813	RECLIPSEN 21	ACG
02417464	RECLIPSEN 28	ACG

ETHINYL ESTRADIOL, DROSPIRENONE

ST **0.02MG & 3MG TABLET**

02415380	MYA	APX
02321157	YAZ	BAY

ST **0.03MG & 3MG TABLET**

02261723	YASMIN 21	BAY
02261731	YASMIN 28	BAY
02410788	ZAMINE 21	APX
02410796	ZAMINE 28	APX
02385058	ZARAH 21	OBT
02385066	ZARAH 28	OBT

ETHINYL ESTRADIOL, ETHYNODIOL DIACETATE

ST **30MCG & 2MG TABLET**

00469327	DEMULEN 30 (21 DAY PACK)	PFI
00471526	DEMULEN 30 (28 DAY PACK)	PFI

ETHINYL ESTRADIOL, ETONOGESTREL

ST **2.6MG & 11.4MG RING (SLOW-RELEASE)**

02253186	NUVARING	FRS

ETHINYL ESTRADIOL, LEVONORGESTREL

0.03MG & 0.15MG TABLET

02398869	INDAYO	MYL

ST **0.15MG & 0.03MG TABLET**

02296659	SEASONALE	TEV

ST **20MCG & 100MCG TABLET**

02236974	ALESSE 21	PFI
02236975	ALESSE 28	PFI
02387875	ALYSENA 21	APX
02387883	ALYSENA 28	APX
02298538	AVIANE 21	TEV
02298546	AVIANE 28	TEV
02388138	ESME 21	MYL
02388146	ESME 28	MYL
02401185	LUTERA 21	OBT
02401207	LUTERA 28	OBT

ST **30MCG & 0.05MG, 40MCG & 0.075MG, 30MCG & 0.125MG TABLET**

00707600	TRIQUILAR 21	BAY
00707503	TRIQUILAR 28	BAY

68:12.00 CONTRACEPTIVES

ETHINYL ESTRADIOL, LEVONORGESTREL

ST **30MCG & 150MCG TABLET**

02042320	MIN-OVRAL 21	PFI
02042339	MIN-OVRAL 28	PFI
02387085	OVIMA 21	APX
02387093	OVIMA 28	APX
02295946	PORTIA 21	TEV
02295954	PORTIA 28	TEV

ETHINYL ESTRADIOL, NORELGESTROMIN

ST **6MG & 0.6MG PATCH (EXTENDED RELEASE)**

02248297	EVRA	JSO

ETHINYL ESTRADIOL, NORETHINDRONE

35MCG & 0.5MG TABLET

02187086	BREVICON 0.5/35 (21-DAY PACK)	PFI
02187094	BREVICON 0.5/35 (28-DAY PACK)	PFI

ST **35MCG & 1MG TABLET**

02189054	BREVICON 1/35 (21-DAY PACK)	PFI
02189062	BREVICON 1/35 (28-DAY PACK)	PFI
02197502	SELECT 1/35 (21-DAY)	PFI
02199297	SELECT 1/35 (28-DAY)	PFI

ETHINYL ESTRADIOL, NORETHINDRONE ACETATE

ST **10MCG & 1MG TABLET**

02417456	LOLO	ALL

ST **20MCG & 1MG TABLET**

00315966	MINESTRIN 1/20 (21-DAY)	WAC
00343838	MINESTRIN 1/20 (28-DAY)	WAC

ST **30MCG & 1.5MG TABLET**

00297143	LOESTRIN	WAC
00353027	LOESTRIN	WAC

ETHINYL ESTRADIOL, NORGESTIMATE

ST **35MCG & 0.25MG TABLET**

01968440	CYCLEN (21 DAY)	JSO
01992872	CYCLEN (28 DAY)	JSO

LEVONORGESTREL

0.75MG TABLET

02364905	NEXT CHOICE	ACG
02371189	OPTION 2	PER
02241674	PLAN B	TEV

1.5MG TABLET

02433532	BACKUP PLAN ONESTEP	APX
02425009	CONTINGENCY ONE	MYL
02293854	PLAN B	TEV

LEVONORGESTREL INTRAUTERINE INSERT

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 2 years.

13.5MG INSERT (EXTENDED-RELEASE)

02408295	JAYDESS	BAY

52MG INSERT (EXTENDED-RELEASE)

02243005	MIRENA	BAY

68:12.00 CONTRACEPTIVES

LEVONORGESTREL, ETHINYL ESTRADIOL

ST **0.15MG & 0.03MG & 0.01MG TABLET**

02346176	SEASONIQUE	TEV

NORETHINDRONE

ST **0.35MG TABLET**

02441306	JENCYCLA	LUP
00037605	MICRONOR 28-DAY	JSO
02410303	MOVISSE	MYL

NORETHINDRONE, ETHINYL ESTRADIOL

35MCG & 0.5MG, 35MCG & 1MG TABLET

02187108	SYNPHASIC 21	PFI
02187116	SYNPHASIC 28	PFI

NORGESTIMATE, ETHINYL ESTRADIOL

ST **25MCG & 0.180MG, 25MCG & 0.215MG, 25MCG & 0.25MG TABLET**

02401967	TRICIRA LO 21	APX
02401975	TRICIRA LO 28	APX
02258560	TRI-CYCLEN LO (21 DAY)	JSO
02258587	TRI-CYCLEN LO (28 DAY)	JSO

ST **35MCG & 0.180MG, 35MCG & 0.215MG, 35MCG & 0.25MG TABLET**

02028700	TRI-CYCLEN 21-DAY	JSO
02029421	TRI-CYCLEN 28-DAY	JSO

ULIPRISTAL ACETATE

Limited use benefit (prior approval not required).

Coverage will be limited to 90 tablets, benefits only for women age 18 to 60 years.

ST **5MG TABLET**

02408163	FIBRISTAL	ALL

68:16.04 ESTROGENS

CONJUGATED ESTROGENS

ST **0.625MG/G CREAM**

02043440	PREMARIN	PFI

ST **0.3MG TABLET (EXTENDED RELEASE)**

02414678	PREMARIN	PFI

ST **0.625MG TABLET (EXTENDED RELEASE)**

02414686	PREMARIN	PFI

ST **1.25MG TABLET (EXTENDED RELEASE)**

02414694	PREMARIN	PFI

CONJUGATED ESTROGENS, MEDROXYPROGESTERONE ACETATE

ST **0.625MG & 2.5MG TABLET**

02242878	PREMPLUS	PFI

ST **0.625MG & 5MG TABLET**

02242879	PREMPLUS	PFI

ESTRADIOL

ST **0.25MG GEL**

02424924	DIVIGEL	TEV

ST **0.5MG GEL**

02424835	DIVIGEL	TEV

ST **1MG GEL**

02424843	DIVIGEL	TEV

68:16.04 ESTROGENS

ESTRADIOL

ST **25MCG PATCH**

02245676	ESTRADOT 25	NVR
02243722	OESCLIM	SEA

ST **37.5MCG PATCH**

02243999	ESTRADOT 37.5	NVR

ST **50MCG PATCH**

02244000	ESTRADOT 50	NVR
02243724	OESCLIM	SEA

ST **75MCG PATCH**

02244001	ESTRADOT 75	NVR

ST **100MCG PATCH**

02244002	ESTRADOT 100	NVR

ST **2MG RING (SLOW-RELEASE)**

02168898	ESTRING	PFI

ST **0.5MG TABLET**

02225190	ESTRACE	TRM

ST **1MG TABLET**

02148587	ESTRACE	TRM

ST **2MG TABLET**

02148595	ESTRACE	TRM

ESTRADIOL HEMIHYDRATE

ST **0.06% GEL**

02238704	ESTROGEL	FRS

ST **25MCG PATCH**

02247499	CLIMARA 25	BAY

ST **50MCG PATCH**

02231509	CLIMARA 50	BAY
02246967	SANDOZ ESTRADIOL DERM	SDZ

ST **75MCG PATCH**

02247500	CLIMARA 75	BAY
02246968	SANDOZ ESTRADIOL DERM	SDZ

ST **100MCG PATCH**

02231510	CLIMARA 100	BAY
02246969	SANDOZ ESTRADIOL DERM	SDZ

ST **0.5MG TABLET**

02449048	LUPIN-ESTRADIOL	LUP

ST **1MG TABLET**

02449056	LUPIN-ESTRADIOL	LUP

ST **2MG TABLET**

02449064	LUPIN-ESTRADIOL	LUP

ST **10MCG VAGINAL TABLET**

02325462	VAGIFEM 10	NOO

ESTRADIOL, LEVONORGESTREL

45MCG & 15MCG PATCH

02250616	CLIMARA PRO	BAY

ESTRADIOL, NORETHINDRONE ACETATE

ST **50MCG & 140MCG PATCH**

02241835	ESTALIS	NVR

ST **50MCG & 250MCG PATCH**

02241837	ESTALIS	NVR

ESTRONE

ST **1MG/G CREAM**

00727369	ESTRAGYN	SEA

68:16.12 ESTROGEN AGONISTS-ANTAGONISTS

RALOXIFENE HYDROCHLORIDE

Limited use benefit (prior approval required).

For secondary prevention of osteoporosis in women who experience failure on bisphosphonates.
For secondary prevention of osteoporosis in women who have a personal history or a first degree relative with a history of breast cancer.

60MG TABLET

02358840	ACT RALOXIFENE	ACG
02279215	APO-RALOXIFENE	APX
02239028	EVISTA	LIL
02358921	PMS-RALOXIFENE	PMS
02415852	RALOXIFENE	PDL
02312298	TEVA-RALOXIFENE	TEV

68:18.00 GONADOTROPINS

GOSERELIN ACETATE

3.6MG/DEPOT IMPLANT

02049325	ZOLADEX	UNK

NAFARELIN ACETATE

2MG/ML AEROSOL

02188783	SYNAREL	PFI

68:20.02 ALPHA-GLUCOSIDASE INHIBITORS

ACARBOSE

ST **50MG TABLET**

02190885	GLUCOBAY	BAY

ST **100MG TABLET**

02190893	GLUCOBAY	BAY

68:20.04 BIGUANIDES

METFORMIN HYDROCHLORIDE

ST **500MG TABLET**

02257726	ACT METFORMIN	ACG
02167786	APO-METFORMIN	APX
02438275	AURO-METFORMIN	AUR
02229994	DOM-METFORMIN	DPC
02421828	ECL-METFORMIN	ECL
02099233	GLUCOPHAGE	SAC
02229516	GLYCON	VAE
02380196	JAMP-METFORMIN	JMP
02380722	JAMP-METFORMIN BLACKBERRY	JMP
02378620	MAR-METFORMIN	MAR
02353377	METFORMIN	SAN
02378841	METFORMIN	MAR
02385341	METFORMIN FC	SIV
02388766	MINT-METFORMIN	MIN
02148765	MYLAN-METFORMIN	MYL
02223562	PMS-METFORMIN	PMS
02314908	PRO-METFORMIN	PDL
02269031	RAN-METFORMIN	RBY
02242974	RATIO-METFORMIN	TEV
02239081	RIVA-METFORMIN	RIV
02246820	SANDOZ METFORMIN FC	SDZ

68:20.04 BIGUANIDES

METFORMIN HYDROCHLORIDE

500MG TABLET

02379767	SEPTA-METFORMIN	SPT
02045710	TEVA-METFORMIN	TEV

850MG TABLET

02257734	ACT METFORMIN	ACG
02229785	APO-METFORMIN	APX
02438283	AURO-METFORMIN	AUR
02242726	DOM-METFORMIN	DPC
02421836	ECL-METFORMIN	ECL
02162849	GLUCOPHAGE	SAC
02239214	GLYCON	VAE
02380218	JAMP-METFORMIN	JMP
02380730	JAMP-METFORMIN BLACKBERRY	JMP
02378639	MAR-METFORMIN	MAR
02353385	METFORMIN	SAN
02378868	METFORMIN	MAR
02385368	METFORMIN FC	SIV
02388774	MINT-METFORMIN	MIN
02229656	MYLAN-METFORMIN	MYL
02242589	PMS-METFORMIN	PMS
02314894	PRO-METFORMIN	PDL
02269058	RAN-METFORMIN	RBY
02242931	RATIO-METFORMIN	TEV
02242783	RIVA-METFORMIN	RIV
02246821	SANDOZ METFORMIN	SDZ
02379775	SEPTA-METFORMIN	SPT
02230475	TEVA-METFORMIN	TEV

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

LINAGLIPTIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

5MG TABLET

02370921	TRAJENTA	BOE

LINAGLIPTIN, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

2.5MG & 1000MG TABLET

02403277	JENTADUETO	BOE

2.5MG & 500MG TABLET

02403250	JENTADUETO	BOE

2.5MG & 850MG TABLET

02403269	JENTADUETO	BOE

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

SAXAGLIPTIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who: did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

2.5MG TABLET

02375842	ONGLYZA	AZC

5MG TABLET

02333554	ONGLYZA	AZC

SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

2.5MG & 1000MG TABLET

02389185	KOMBOGLYZE	AZC

2.5MG & 500MG TABLET

02389169	KOMBOGLYZE	AZC

2.5MG & 850MG TABLET

02389177	KOMBOGLYZE	AZC

SITAGLIPTIN PHOSPHATE MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

25MG TABLET

02388839	JANUVIA	FRS

50MG TABLET

02388847	JANUVIA	FRS

100MG TABLET

02303922	JANUVIA	FRS

SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

50MG & 1000MG TABLET

02333872	JANUMET	FRS

50MG & 500MG TABLET

02333856	JANUMET	FRS

50MG & 850MG TABLET

02333864	JANUMET	FRS

50MG & 1000MG TABLET (EXTENDED RELEASE)

02416794	JANUMET XR	FRS

50MG & 500MG TABLET (EXTENDED RELEASE)

02416786	JANUMET XR	FRS

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

100MG & 1000MG TABLET (EXTENDED RELEASE)

02416808	JANUMET XR	FRS

68:20.08 INSULINS

INSULIN (30% NEUTRAL & 70% ISOPHANE) HUMAN BIOSYNTHETIC

100U/ML INJECTION

00795879	HUMULIN 30/70	LIL
01959212	HUMULIN 30/70 CARTRIDGE	LIL
09853855	HUMULIN 30/70 CARTRIDGE	LIL
02024217	NOVOLIN GE 30/70	NOO
02025248	NOVOLIN GE 30/70 PENFILL	NOO
09853812	NOVOLIN GE 30/70 PENFILL	NOO

INSULIN (40% NEUTRAL & 60% ISOPHANE) HUMAN BIOSYNTHETIC

100U/ML INJECTION

02024314	NOVOLIN GE 40/60 PENFILL	NOO

INSULIN (50% NEUTRAL & 50% ISOPHANE) HUMAN BIOSYNTHETIC

100U/ML INJECTION

02024322	NOVOLIN GE 50/50 PENFILL	NOO

INSULIN (ISOPHANE) HUMAN BIOSYNTHETIC

100U/ML INJECTION

00587737	HUMULIN N	LIL
01959239	HUMULIN N (CARTRIDGE)	LIL
02403447	HUMULIN N (KWIKPEN)	LIL
09853804	HUMULIN N 100U/ML (CARTRIDGE)	LIL
02024225	NOVOLIN GE NPH	NOO
09853782	NOVOLIN GE NPH 100U/ML PENFILL	NOO
02024268	NOVOLIN GE NPH PENFILL	NOO

INSULIN (ZINC CRYSTALLINE) HUMAN BIOSYNTHETIC (RDNA ORIGIN)

100U/ML INJECTION

00586714	HUMULIN R	LIL
09853766	HUMULIN R 100U/ML (CARTRIDGE)	LIL
01959220	HUMULIN R CARTRIDGE	LIL

INSULIN ASPART

100U/ML INJECTION

02244353	NOVORAPID	NOO
02245397	NOVORAPID	NOO
02377209	NOVORAPID	NOO

INSULIN BIOSYNTHETIC HUMAN BR

100U SOLUTION

02415089	HUMULIN R (KWIKPEN)	LIL

68:20.08 INSULINS

INSULIN DETEMIR

100U/ML INJECTION

02412829	LEVEMIR FLEXTOUCH	NOO
02271842	LEVEMIR PENFILL	NOO

INSULIN GLARGINE

100U/ML INJECTION

02245689	LANTUS	SAC
02251930	LANTUS	SAC
02294338	LANTUS SOLOSTAR	SAC

INSULIN GLULISINE

100U/ML INJECTION

02279479	APIDRA CARTRIDGE	SAC
02294346	APIDRA SOLOSTAR	SAC
02279460	APIDRA VIAL	SAC

INSULIN HUMAN BIOSYNTHETIC

100U/ML INJECTION

02024233	NOVOLIN GE TORONTO	NOO
02024284	NOVOLIN GE TORONTO PENFILL	NOO
09853774	NOVOLIN GE TORONTO PENFILL	NOO

INSULIN LISPRO

100U/ML INJECTION

02229704	HUMALOG	LIL
02229705	HUMALOG (CARTRIDGE)	LIL
02403412	HUMALOG (KWIKPEN)	LIL
09853715	HUMALOG 100U/ML CARTRIDGE	LIL

200U/ML INJECTION

02439611	HUMALOG 200U/ML KWIKPEN	LIL

INSULIN LISPRO, INSULIN LISPRO PROTAMINE

100U/ML INJECTION

02240294	HUMALOG MIX 25 (CARTRIDGE)	LIL
02403420	HUMALOG MIX 25 (KWIKPEN)	LIL
02240297	HUMALOG MIX 50 (CARTRIDGE)	LIL
02403439	HUMALOG MIX 50 (KWIKPEN)	LIL

68:20.16 MEGLITINIDES

REPAGLINIDE

0.5MG TABLET

02321475	ACT REPAGLINIDE	ACG
02355663	APO-REPAGLINIDE	APX
02424258	AURO-REPAGLINIDE	AUR
02239924	GLUCONORM	NOO
02354926	PMS-REPAGLINIDE	PMS
02415968	REPAGLINIDE	PDL
02357453	SANDOZ REPAGLINIDE	SDZ

1MG TABLET

02321483	ACT REPAGLINIDE	ACG
02355671	APO-REPAGLINIDE	APX
02424266	AURO-REPAGLINIDE	AUR
02239925	GLUCONORM	NOO
02354934	PMS-REPAGLINIDE	PMS
02415976	REPAGLINIDE	PDL
02357461	SANDOZ REPAGLINIDE	SDZ

68:20.16 MEGLITINIDES

REPAGLINIDE

2MG TABLET

02321491	ACT REPAGLINIDE	ACG
02355698	APO-REPAGLINIDE	APX
02424274	AURO-REPAGLINIDE	AUR
02239926	GLUCONORM	NOO
02354942	PMS-REPAGLINIDE	PMS
02415984	REPAGLINIDE	PDL
02357488	SANDOZ REPAGLINIDE	SDZ

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

CANAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

100MG TABLET

02425483	INVOKANA	JSO

300MG TABLET

02425491	INVOKANA	JSO

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

5MG TABLET

02435462	FORXIGA	AZC

10MG TABLET

02435470	FORXIGA	AZC

EMPAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

10MG TABLET

02443937	JARDIANCE	BOE

25MG TABLET

02443945	JARDIANCE	BOE

METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

850MG & 5MG TABLET

02449935	XIGDUO	AZC

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

1000MG & 5MG TABLET

02449943	XIGDUO	AZC

68:20.20 ANTIDIABETIC AGENTS - SULFONYLUREAS

GLICLAZIDE

80MG TABLET

02245247	APO-GLICLAZIDE	APX
00765996	DIAMICRON	SEV
02248453	GLICLAZIDE	PDL
02287072	GLICLAZIDE	SAN
02229519	MYLAN-GLICLAZIDE	MYL
02238103	TEVA-GLICLAZIDE	TEV

30MG TABLET (EXTENDED RELEASE)

02297795	APO-GLICLAZIDE MR	APX
02242987	DIAMICRON MR	SEV
02429764	GPC-GLICLAZIDE MR	UNK
02423286	MINT-GLICLAZIDE MR	MIN
02438658	MYLAN-GLICLAZIDE MR	MYL
02461323	SANDOZ GLICLAZIDE MR	SDZ

60MG TABLET (EXTENDED RELEASE)

02407124	APO-GLICLAZIDE MR	APX
02356422	DIAMICRON MR	SEV
02423294	MINT-GLICLAZIDE MR	MIN
02439328	RAN-GLICLAZIDE	RBY
02461331	SANDOZ GLICLAZIDE MR	SDZ

GLYBURIDE

2.5MG TABLET

01913654	APO GLYBURIDE	APX
02224550	DIABETA	SAC
01959352	GLYBURIDE	PDL
02350459	GLYBURIDE	SAN
01913670	TEVA-GLYBURIDE	TEV

5MG TABLET

01913662	APO GLYBURIDE	APX
02224569	DIABETA	SAC
02234514	DOM-GLYBURIDE	DPC
00720941	EUGLUCON	PMS
02350467	GLYBURIDE	SAN
02236734	PMS-GLYBURIDE	PMS
02316544	PRO-GLYBURIDE	PDL
01913689	TEVA-GLYBURIDE	TEV

TOLBUTAMIDE

500MG TABLET

00312762	TOLBUTAMIDE	AAP

68:20.28 THIAZOLIDINEDIONES

PIOGLITAZONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

15MG TABLET

02303442	ACCEL PIOGLITAZONE	ACP
02391600	ACH-PIOGLITAZONE	ACC
02302861	ACT PIOGLITAZONE	ACG
02242572	ACTOS	TAK
02302942	APO-PIOGLITAZONE	APX
02307634	DOM-PIOGLITAZONE	DPC
02397307	JAMP-PIOGLITAZONE	JMP
02326477	MINT-PIOGLITAZONE	MIN
02298279	MYLAN-PIOGLITAZONE	MYL
02303124	PMS-PIOGLITAZONE	PMS
02312050	PRO-PIOGLITAZONE	PDL
02375850	RAN-PIOGLITAZONE	RBY
02297906	SANDOZ PIOGLITAZONE	SDZ
02274914	TEVA-PIOGLITAZONE	TEV
02434121	VAN-PIOGLITAZONE	VAN

30MG TABLET

02303450	ACCEL PIOGLITAZONE	ACP
02339587	ACH-PIOGLITAZONE	ACC
02302888	ACT PIOGLITAZONE	ACG
02242573	ACTOS	TAK
02302950	APO-PIOGLITAZONE	APX
02307642	DOM-PIOGLITAZONE	DPC
02365529	JAMP-PIOGLITAZONE	JMP
02326485	MINT-PIOGLITAZONE	MIN
02298287	MYLAN-PIOGLITAZONE	MYL
02303132	PMS-PIOGLITAZONE	PMS
02312069	PRO-PIOGLITAZONE	PDL
02375869	RAN-PIOGLITAZONE	RBY
02297914	SANDOZ PIOGLITAZONE	SDZ
02274922	TEVA-PIOGLITAZONE	TEV
02434148	VAN-PIOGLITAZONE	VAN

45MG TABLET

02303469	ACCEL PIOGLITAZONE	ACP
02339595	ACH-PIOGLITAZONE	ACC
02302896	ACT PIOGLITAZONE	ACG
02242574	ACTOS	TAK
02302977	APO-PIOGLITAZONE	APX
02307650	DOM-PIOGLITAZONE	DPC
02365537	JAMP-PIOGLITAZONE	JMP
02326493	MINT-PIOGLITAZONE	MIN
02298295	MYLAN-PIOGLITAZONE	MYL
02303140	PMS-PIOGLITAZONE	PMS
02312077	PRO-PIOGLITAZONE	PDL
02375877	RAN-PIOGLITAZONE	RBY
02297922	SANDOZ PIOGLITAZONE	SDZ
02274930	TEVA-PIOGLITAZONE	TEV
02434156	VAN-PIOGLITAZONE	VAN

68:20.28 THIAZOLIDINEDIONES

ROSIGLITAZONE MALEATE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

2MG TABLET

02403366	APO-ROSIGLITAZONE	APX
02241112	AVANDIA	GSK

4MG TABLET

02403374	APO-ROSIGLITAZONE	APX
02241113	AVANDIA	GSK

8MG TABLET

02403382	APO-ROSIGLITAZONE	APX
02241114	AVANDIA	GSK

68:22.12 GLYCOGENOLYTIC AGENTS

GLUCAGON RECOMBINANT DNA ORGIN

1MG/ML INJECTION

02333619	GLUCAGEN	NOO
02333627	GLUCAGEN HYPOKIT	NOO
02243297	GLUCAGON	LIL

68:24.00 PARATHYROID

CALCITONIN SALMON (SYNTHETIC)

200IU/ML SOLUTION

01926691	CALCIMAR	SAC

68:28.00 PITUITARY

DESMOPRESSIN ACETATE

4MCG/ML LIQUID

00873993	DDAVP	FEI

0.1MG/ML NASAL SPRAY

00402516	DDAVP	FEI
00836362	DDAVP	FEI
02242465	DESMOPRESSIN	AAP

0.1MG TABLET

00824305	DDAVP	FEI
02284030	DESMOPRESSIN	APX
02304368	PMS-DESMOPRESSIN	PMS
02287730	TEVA-DESMOPRESSIN	TEV

0.2MG TABLET

00824143	DDAVP	FEI
02284049	DESMOPRESSIN	APX
02304376	PMS-DESMOPRESSIN	PMS
02287749	TEVA-DESMOPRESSIN	TEV

60MCG TABLET (ORALLY DISINTEGRATING)

02284995	DDAVP MELT	FEI

120MCG TABLET (ORALLY DISINTEGRATING)

02285002	DDAVP MELT	FEI

240MCG TABLET (ORALLY DISINTEGRATING)

02285010	DDAVP MELT	FEI

68:32.00 PROGESTINS

DIENOGEST

Limited use benefit (prior approval required).

For the management of pelvic pain associated with endometriosis.

2MG TABLET

02374900	VISANNE	BAY

MEDROXYPROGESTERONE ACETATE

50MG/ML SUSPENSION

00030848	DEPO-PROVERA	PFI

150MG/ML SUSPENSION

00585092	DEPO-PROVERA	PFI
02322250	MEDROXYPROGESTERONE	SDZ

2.5MG TABLET

02244726	APO-MEDROXY	APX
02253550	MEDROXY	PDL
00708917	PROVERA	PFI
02221284	TEVA-MEDROXYPROGESTERONE	TEV

5MG TABLET

02244727	APO-MEDROXY	APX
02253577	MEDROXY	PDL
00030937	PROVERA	PFI
02221292	TEVA-MEDROXYPROGESTERONE	TEV

10MG TABLET

02277298	APO-MEDROXY	APX
00729973	PROVERA	PFI
02221306	TEVA-MEDROXYPROGESTERONE	TEV

100MG TABLET

02267640	APO-MEDROXY	APX

PROGESTERONE

Limited use benefit (prior approval required).

For the treatment of women:
- With postmenopausal symptoms who are intolerant to medroxyprogesterone acetate (MPA); OR
- Who are at risk of preterm birth; OR
- Who are using the medication to prevent miscarriage.

100MG CAPSULE

02166704	PROMETRIUM	FRS
02439913	TEVA-PROGESTERONE	TEV

68:36.04 THYROID AGENTS

LEVOTHYROXINE SODIUM

0.025MG TABLET

02264323	EUTHYROX	SRO
02172062	SYNTHROID	BGP

0.05MG TABLET

02213192	ELTROXIN	ASP
02264331	EUTHYROX	SRO
02172070	SYNTHROID	BGP

0.075MG TABLET

02264358	EUTHYROX	SRO
02172089	SYNTHROID	BGP

0.088MG TABLET

02172097	SYNTHROID	BGP

0.1MG TABLET

02213206	ELTROXIN	ASP

68:36.04 THYROID AGENTS

LEVOTHYROXINE SODIUM

0.1MG TABLET

02264374	EUTHYROX	SRO
02172100	SYNTHROID	BGP

0.112MG TABLET

02264390	EUTHYROX	SRO
02171228	SYNTHROID	BGP

0.125MG TABLET

02264404	EUTHYROX	SRO
02172119	SYNTHROID	BGP

0.137MG TABLET

02264412	EUTHYROX	SRO
02233852	SYNTHROID	BGP

0.15MG TABLET

02213214	ELTROXIN	ASP
02264420	EUTHYROX	SRO
02172127	SYNTHROID	BGP

0.175MG TABLET

02264439	EUTHYROX	SRO
02172135	SYNTHROID	BGP

0.2MG TABLET

02213222	ELTROXIN	ASP
02264447	EUTHYROX	SRO
02172143	SYNTHROID	BGP

0.3MG TABLET

02213230	ELTROXIN	ASP
02264455	EUTHYROX	SRO
02172151	SYNTHROID	BGP

LIOTHYRONINE SODIUM

5MCG TABLET

01919458	CYTOMEL	PFI

25MCG TABLET

01919466	CYTOMEL	PFI

THYROID

30MG TABLET

00023949	THYROID	ERF

60MG TABLET

00023957	THYROID	ERF

125MG TABLET

00023965	THYROID	ERF

68:36.08 ANTITHYROID AGENTS

PROPYLTHIOURACIL

50MG TABLET

00010200	PROPYL-THYRACIL	PAL

100MG TABLET

00010219	PROPYL-THYRACIL	PAL

THIAMAZOLE

5MG TABLET

00015741	TAPAZOLE	PAL

10MG TABLET

02296039	TAPAZOLE	PAL

72:00 LOCAL ANESTHETICS

72:00.00 LOCAL ANESTHETICS

LIDOCAINE HYDROCHLORIDE

2% LIQUID

01968823	LIDODAN VISCOUS	ODN
00811874	PMS-LIDOCAINE VISCOUS	PMS

84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)

84:04.04 SMMA - ANTIBIOTICS

BACITRACIN ZINC

500IU OINTMENT

00584908	BACITIN	PED
02351714	JAMP-BACITRACINE	JMP

CLINDAMYCIN PHOSPHATE

2% CREAM

02060604	DALACIN	PFI

1% SOLUTION

02243659	CLINDA-T	VAE
00582301	DALACIN T	PFI
02266938	TARO-CLINDAMYCIN	TAR

PDIN FOR EXTEMPORANEOUS MIXTURE

99502000	CLINDAMYCIN IN DILUSOL OR DUONALC	UNK

CLINDAMYCIN PHOSPHATE, BENZOYL PEROXIDE

1% & 3% GEL

02382822	CLINDOXYL ADV	GSK

1% & 5% GEL

02248472	BENZACLIN	VAE
02243158	CLINDOXYL	GSK
02464519	TARO-BENZOYL PEROXIDE / CLINDAMYCIN KIT	TAR
02440180	TARO-CLINDAMYCIN/BENZOYL PEROXIDE	TAR

ERYTHROMYCIN, BENZOYL PEROXIDE

3% & 5% GEL

02225271	BENZAMYCIN	VAE

FUSIDATE SODIUM

2% OINTMENT

00586676	FUCIDIN	LEO

FUSIDIC ACID

2% CREAM

00586668	FUCIDIN	LEO

METRONIDAZOLE

1% CREAM

02156091	NORITATE	VAE

0.75% GEL

02092832	METROGEL	GAC
02125226	NIDAGEL	VAE

1% GEL

02297809	METROGEL	GAC

0.75% LOTION

02248206	METROLOTION	GAC

METRONIDAZOLE, NYSTATIN

500MG & 100,000IU SUPPOSITORY

01926829	FLAGYSTATIN	SAC

84:04.04 SMMA - ANTIBIOTICS

MUPIROCIN

2% OINTMENT

01916947	BACTROBAN	GSK
02279983	TARO-MUPIROCIN	TAR

MUPIROCIN CALCIUM

2% CREAM

02239757	BACTROBAN	GSK

POLYMYXIN B SULFATE, BACITRACIN ZINC

10,000IU & 500IU OINTMENT

02304473	ANTIBIOTIC OINT	PMS
00876488	BACIMYXIN ONGUENT	PMS
00621366	BIODERM	ODN
02357569	JAMPOLYCIN	JMP
02237227	POLYSPORIN ANTIBIOTIC	JAJ
01942921	POLYTOPIC	SDZ

POLYMYXIN B SULFATE, GRAMICIDIN

0.25MG & 10,000IU CREAM

02230844	POLYSPORIN ANTIBIOTIC	JAJ

84:04.06 SMMA - ANTIVIRALS

ACYCLOVIR

5% CREAM

02039524	ZOVIRAX	VAE

5% OINTMENT

00569771	ZOVIRAX	VAE

84:04.08 SMMA - ANTIFUNGALS

BETAMETHASONE DIPROPIONATE, CLOTRIMAZOLE

0.05% & 1% CREAM

00611174	LOTRIDERM	FRS

CICLOPIROX OLAMINE

1% CREAM

02221802	LOPROX	VAE

1% LOTION

02221810	LOPROX	VAE

CLOTRIMAZOLE

1% CREAM

02150867	CANESTEN	BAY
02150891	CANESTEN	BAY
00812366	CLOTRIMADERM	TAR
00812382	CLOTRIMADERM	TAR
02229380	CLOTRIMAZOLE	TAR
00874043	NEO-ZOL	PPI
00874051	NEO-ZOL	PPI

2% CREAM

02150905	CANESTEN	BAY
00812374	CLOTRIMADERM	TAR

1% & 200MG TABLET (CONTROLLED RELEASE)

02264099	CANESTEN COMBI-PAK COMFORTAB 3	BAY

1% & 500MG TABLET (CONTROLLED RELEASE)

02264102	CANESTEN COMBI-PAK COMFORTAB 1	BAY

84:04.08 SMMA - ANTIFUNGALS

KETOCONAZOLE

2% CREAM

02245662	KETODERM	TPT

2% SHAMPOO

02182920	NIZORAL	JAJ

MICONAZOLE NITRATE

2% CREAM

02085852	MICATIN	WPC
02231106	MICOZOLE	TAR
02084309	MONISTAT 7	INS
02126567	MONISTAT DERM	INS

2% & 100MG CREAM/VAGINAL SUPPOSITORY

02126257	MONISTAT 7 DUAL-PAK	INS

2% & 400MG CREAM/VAGINAL SUPPOSITORY

02126249	MONISTAT 3 DUAL-PAK	INS

400MG OVULE

02126605	MONISTAT 3	INS

400MG SUPPOSITORY

02171775	MICONAZOLE 3 DAY OVULE TREATMENT	VTH

NYSTATIN

25,000IU CREAM

00716901	NYADERM	TAR

100,000IU CREAM

00716871	NYADERM	TAR
02194163	RATIO-NYSTATIN	TEV
02194236	RATIO-NYSTATIN	TEV

100,000IU OINTMENT

02194228	RATIO-NYSTATIN	TEV

TERBINAFINE HYDROCHLORIDE

1% CREAM

02031094	LAMISIL	NVR

TERCONAZOLE

0.4% CREAM

02247651	TARO-TERCONAZOLE	TAR

TOLNAFTATE

1% AEROSOL

00576050	TINACTIN AEROSOL	BAY

1% CREAM

00576034	TINACTIN	BAY

1% POWDER

01919245	DRSCHOLL'S ATHLETE'S FOOT SPRAY	BAY
00576042	TINACTIN	BAY

84:04.12 SMMA - SCABICIDES AND PEDICULICIDES

CROTAMITON

10% CREAM

00623377	EURAX	CLC

DIMETHICONE

50% SOLUTION

02373785	NYDA	GPB

84:04.12 SMMA - SCABICIDES AND PEDICULICIDES

ISOPROPYL MYRISTATE

50% SOLUTION

02279592	RESULTZ	MDF

PERMETHRIN

1% CREAM

00771368	NIX	INS

5% CREAM

02219905	NIX DERMAL	GSK

1% LIQUID

02231480	KWELLADA-P	MTC

5% LOTION

02231348	KWELLADA-P	MTC

PIPERONYL BUTOXIDE, PYRETHRINS

3% & 0.3% SHAMPOO

02125447	R & C SHAMPOO WITH CONDITIONER	MTC

84:04.92 SMMA - MISCELLANEOUS LOCAL ANTI-INFECTIVES

ISOPROPYL ALCOHOL

70% LIQUID

00426539	DUONALC	ICN

METRONIDAZOLE

10% CREAM

01926861	FLAGYL	SAC

POVIDONE-IODINE

10% SOLUTION

00158348	BETADINE	PFR

SELENIUM SULFIDE

2.5% LOTION

00594601	VERSEL	VAE

2.5% SHAMPOO

00243000	EXTRA STRENGTH SELSUN	SAC

SILVER SULFADIAZINE

1% CREAM

00323098	FLAMAZINE	SNE
09854037	FLAMAZINE	SMW

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

AMCINONIDE

0.1% CREAM

02192284	CYCLOCORT	GSK
02247098	RATIO-AMCINONIDE	TEV
02246714	TARO-AMCINONIDE	TAR

0.1% LOTION

02247097	RATIO-AMCINONIDE	TEV

0.1% OINTMENT

02192268	CYCLOCORT	GSK
02247096	RATIO-AMCINONIDE	TEV

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

BECLOMETHASONE DIPROPIONATE

0.025% CREAM

02089602	PROPADERM	VAE

BETAMETHASONE DIPROPIONATE

0.05% CREAM

00688622	DIPROLENE	FRS
00323071	DIPROSONE	FRS
02122073	ROLENE	RIV
02122049	ROSONE	RIV
01925350	TARO-SONE	TAR
00849650	TEVA-TOPILENE	TEV
00804991	TEVA-TOPISONE	TEV

0.05% LOTION

00417246	DIPROSONE	FRS
02122065	ROLENE	RIV
02122030	ROSONE	RIV
01927914	TEVA-TOPILENE	TEV
00809187	TEVA-TOPISONE	TEV

0.05% OINTMENT

00629367	DIPROLENE	FRS
00344923	DIPROSONE	FRS
02122081	ROLENE	RIV
02122057	ROSONE	RIV
00849669	TEVA-TOPILENE	TEV
00805009	TEVA-TOPISONE	TEV

BETAMETHASONE DIPROPIONATE, SALICYLIC ACID

0.05% & 2% LOTION

00578428	DIPROSALIC	FRS
02245688	RATIO-TOPISALIC	TEV

0.05% & 3% OINTMENT

00578436	DIPROSALIC	FRS

PDIN FOR EXTEMPORANEOUS MIXTURE

99500003	SALICYLIC ACID IN CORTICOSTEROID CREAM	UNK
99501001	SALICYLIC ACID IN NON-MEDICATED OINTMENT	UNK

BETAMETHASONE VALERATE

0.05% CREAM

00716618	BETADERM	TAR
02357860	CELESTODERM V	VAE
00535427	RATIO-ECTOSONE	TEV

0.1% CREAM

00716626	BETADERM	TAR
02357844	CELESTODERM V	VAE
00804541	PREVEX B	GSK
00535435	RATIO-ECTOSONE	TEV

0.05% LOTION

00653209	RATIO-ECTOSONE	TEV

0.1% LOTION

00716634	BETADERM	TAR
00653217	RATIO-ECTOSONE	TEV
00750050	RATIO-ECTOSONE	TEV
01940112	RIVASONE	RIV

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

BETAMETHASONE VALERATE

0.1% LOTION

00027944	VALISONE	VAE

0.05% OINTMENT

00716642	BETADERM	TAR
02357879	CELESTODERM V	VAE

0.1% OINTMENT

00716650	BETADERM	TAR
02357852	CELESTODERM V	VAE

BUDESONIDE, SODIUM CHLORIDE

0.02MG/ML ENEMA

02052431	ENTOCORT	TIL

CALCIPOTRIOL, BETAMETHASONE DIPROPIONATE

50MCG & 0.5MG AEROSOL, FOAM

02457393	ENSTILAR	LEO

0.5MG & 50MCG GEL

02319012	DOVOBET	LEO

0.5MG & 50MCG OINTMENT

02244126	DOVOBET	LEO

CLOBETASOL PROPIONATE

0.05% CREAM

02213265	DERMOVATE	TPT
02024187	MYLAN-CLOBETASOL	MYL
02093162	NOVO-CLOBETASOL	NOP
02232191	PMS-CLOBETASOL	PMS
02309521	PMS-CLOBETASOL	PMS
02245523	TARO-CLOBETASOL	TAR
01910272	TEVA-CLOBETASOL	TEV

0.05% LOTION

02213281	DERMOVATE	TPT
02216213	MYLAN-CLOBETASOL	MYL
02232195	PMS-CLOBETASOL	PMS
02245522	TARO-CLOBETASOL	TAR
01910299	TEVA-CLOBETASOL	TEV

0.05% OINTMENT

02213273	DERMOVATE	TPT
02026767	MYLAN-CLOBETASOL	MYL
02126192	NOVO-CLOBETASOL	NOP
02309548	PMS-CLOBETASOL	PMS
02245524	TARO-CLOBETASOL	TAR
01910280	TEVA-CLOBETASOL	TEV

CLOBETASONE BUTYRATE

0.05% CREAM

02214415	SPECTRO ECZEMACARE	GSK

DESONIDE

0.05% CREAM

02229315	PDP-DESONIDE	PED
02154862	TRIDESILON	PER

0.05% OINTMENT

02229323	PDP-DESONIDE	PED
02154870	TRIDESILON	PER

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

DESOXIMETASONE

0.05% CREAM

02221918	TOPICORT MILD	VAE

0.25% CREAM

02221896	TOPICORT	VAE

0.05% GEL

02221926	TOPICORT	VAE

0.25% OINTMENT

02221934	TOPICORT	VAE

ESCULIN, FRAMYCETIN SULFATE, DIBUCAINE HYDROCHLORIDE, HYDROCORTISONE ACETATE

1% & 1% & 0.5% & 0.5% OINTMENT

02247322	PROCTOL	ODN
02223252	PROCTOSEDYL	APC
02242527	SANDOZ PROCTOMYXIN HC	SDZ

10MG & 10MG & 5MG & 5MG OINTMENT

02226383	RATIO-PROCTOSONE	TEV

1% & 1% & 0.5% & 0.5% SUPPOSITORY

02247882	PROCTOL	ODN
02223260	PROCTOSEDYL	APC
02242528	SANDOZ PROCTOMYXIN HC	SDZ

10MG & 10MG & 5MG & 5MG SUPPOSITORY

02226391	RATIO-PROCTOSONE	TEV

FLUOCINONIDE

0.05% CREAM

02163152	LIDEMOL	VAE
02161923	LIDEX	VAE
00716863	LYDERM	TPT
00598933	TIAMOL	TPT

0.05% GEL

02161974	LIDEX	VAE
02236997	LYDERM	TPT

0.01% LOTION

00873292	DERMA-SMOOTHE	HIL

0.025% OINTMENT

02162512	SYNALAR	VAE

0.05% OINTMENT

02161966	LIDEX	VAE
02236996	LYDERM	TPT

0.01% SOLUTION

02162504	SYNALAR	VAE

HALOBETASOL PROPIONATE

0.05% CREAM

01962701	ULTRAVATE	VAE

0.05% OINTMENT

01962728	ULTRAVATE	VAE

HYDROCORTISONE ACETATE

0.5% CREAM

80021088	CORTATE	BAY
00716820	HYDERM	TAR
02242930	HYDROCORTISONE ACETATE	TAR

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE

1% CREAM

00192597	EMOCORT	GSK
02412926	EUROHYDROCORTISONE	EUR
00716839	HYDERM	TAR
00564281	HYDROSONE	TEV
80057178	JAMP-HC	JMP
80057189	JAMP-HYDROCORTISONE	JMP
80066164	M-HC	MAN
00804533	PREVEX HC	GSK

0.5% LOTION

80021087	CORTATE	BAY

1% LOTION

00192600	EMO CORT	GSK
80057191	JAMP-HYDROCORTISONE	JMP
80066168	M-HC	MAN
00578541	SARNA HC	GSK

0.5% OINTMENT

80021085	CORTATE	BAY
00716685	CORTODERM	TAR

1% OINTMENT

00716693	CORTODERM OINT	TAR

HYDROCORTISONE ACETATE, UREA

1% CREAM

80073645	M-HC UREA	MAN

1% & 10% CREAM

00681989	DERMAFLEX HC	PAL

1% LOTION

80073689	M-HC UREA	MAN

1.00% LOTION

00681997	DERMAFLEX HC	PAL

HYDROCORTISONE ACETATE, ZINC SULFATE

0.5% & 0.5% OINTMENT

02128446	ANODAN-HC	ODN
00505773	ANUSOL HC	CHU
02209764	EGOZINC-HC	PMS
00607789	RATIO-HEMCORT-HC	TEV
02179547	RIVA-HC	RIV
02247691	SANDOZ ANUZINC HC	SDZ

10MG & 10MG SUPPOSITORY

02236399	ANODAN-HC	ODN
00476285	ANUSOL HC	CHU
02210517	EGOZINC-HC	PMS
00607797	RATIO-HEMCORT-HC	TEV
02240112	RIVASOL-HC	RIV
02242798	SANDOZ ANUZINC HC	SDZ

HYDROCORTISONE ACETATE, ZINC SULFATE MONOHYDRATE

0.5% & 0.5% OINTMENT

02387239	JAMP-ZINC-HC	JMP

84:06.00 SMMA - ANTI-INFLAMMATORY AGENTS

HYDROCORTISONE ACETATE, ZINC SULFATE, PRAMOXINE HYDROCHLORIDE

0.5% & 0.5% & 1% OINTMENT

00505781	ANUGESIC HC	MCL
02234466	PROCTODAN-HC	ODN

10MG & 10MG & 20MG SUPPOSITORY

00476242	ANUGESIC HC	MCL
02240851	PROCTODAN-HC	ODN
02242797	SANDOZ ANUZINC HC PLUS	SDZ

HYDROCORTISONE VALERATE

0.2% CREAM

02242984	HYDROVAL	TPT

0.2% OINTMENT

02242985	HYDROVAL	TPT

MOMETASONE FUROATE

0.1% CREAM

00851744	ELOCOM	FRS
02367157	TARO-MOMETASONE	TAR

0.1% LOTION

00871095	ELOCOM	FRS

0.1% OINTMENT

00851736	ELOCOM	FRS
02244769	PMS-MOMETASONE	PMS
02270862	PMS-MOMETASONE	PMS
02248130	RATIO-MOMETASONE	TEV
02264749	TARO-MOMETASONE	TAR
02266385	TARO-MOMETASONE	TAR

PDIN FOR EXTEMPORANEOUS MIXTURE

99500008	MOMETASONE CREAM	UNK

TRIAMCINOLONE ACETONIDE

0.1% CREAM

02194058	ARISTOCORT R	VAE
00716960	TRIADERM	TAR

0.5% CREAM

02194066	ARISTOCORT C	VAE

0.1% OINTMENT

02194031	ARISTOCORT R	VAE

0.1% PASTE

01964054	ORACORT DENTAL PASTE	TAR

84:08.00 SMMA - ANTIPRURITICS AND LOCAL ANESTHETICS

LIDOCAINE HYDROCHLORIDE

2% SOLUTION

02427745	JAMPOCAINE VISCOUS	JMP

LIDOCAINE, PRILOCAINE

2.5% & 2.5% CREAM

00886858	EMLA	UNK

2.5% & 2.5% PATCH

02057794	EMLA	UNK

84:16.00 SMMA - CELL STIMULANTS AND PROLIFERANTS

TRETINOIN

0.01% CREAM

00897329	RETIN-A	VAE
00657204	STIEVA-A	GSK

0.025% CREAM

00897310	RETIN-A	VAE
00578576	STIEVA-A	GSK

0.05% CREAM

00443794	RETIN-A	VAE
00518182	STIEVA-A	GSK

0.1% CREAM

00870021	RETIN-A	VAE

0.01% GEL

00870013	RETIN-A	VAE
01926462	VITAMIN A ACID	VAE

0.025% GEL

00443816	RETIN-A	VAE
01926470	VITAMIN A ACID	VAE

0.05% GEL

01926489	VITAMIN A ACID	VAE

84:24.12 BASIC OINTMENTS AND PROTECTANTS

DIMETHICONE

20% CREAM

02060841	BARRIERE	WPC

PETROLATUM

67% CREAM

00635189	PREVEX	GSK

WHITE PETROLATUM

71.5% OINTMENT

02277778	CRITIC-AID CLEAR	UNK

ZINC OXIDE

15% CREAM

02215799	ZINC OXIDE	HJS

25% OINTMENT

00532576	PATE D'IHLE	TEV
00886327	PÂTE D'IHLE	ATL

ZINC OXIDE, WHITE PETROLATUM

15% & 80.3% CREAM

02337452	DIAPER RASH	HJS

40% OINTMENT

02239160	ZINCOFAX EXTRA STRENGTH	PAL

84:28.00 KERATOLYTIC AGENTS

BENZOYL PEROXIDE

5% GEL

02162113	BENZAGEL	CLC

5% LIQUID

02162121	BENZAGEL	CLC

4% LOTION

02413353	SPECTRO ACNECARE WASH	GSK

84:28.00 KERATOLYTIC AGENTS

BENZOYL PEROXIDE

5% LOTION

02166607	BENZAGEL 5	CLC

CANTHARIDIN, PODOPHYLLIN, SALICYLIC ACID

1% & 2% & 30% LIQUID

00772011	CANTHARONE PLUS	DOR

1% & 5% & 30% LIQUID

00589500	CANTHACUR-PS	PAL

SALICYLIC ACID

170MG/ML GEL

00614246	COMPOUND W GEL	UNK

20% LIQUID

00690333	SOLUVER	DPT

26% LIQUID

00754951	OCCLUSAL HP	VAE

27% LIQUID

00837733	SOLUVER PLUS	DPT

40% MISCELLANEOUS

01967878	CLEAR AWAY PLANTAR WART SYSTEM	BAY
01974335	CLEAR AWAY WART REMOVER SYSTEM	BAY

4% SHAMPOO

00666106	SEBCUR	DPT

SALICYLIC ACID-LACTIC ACID

16.716.7/% LIQUID

00370576	DUOFILM	STI

84:32.00 KERATOPLASTIC AGENTS

COAL TAR

10% GEL

00344508	TARGEL	ODN

20% LIQUID

00358495	ODAN LIQUOR CARBONIS DETERGENT	ODN

0.5% SHAMPOO

02240645	NEUTROGENA	JAJ

1% SHAMPOO

02307146	T/ THERAPEUTIC SHAMPOO EXTRA STRENGTH	JAJ

COAL TAR, SALICYLIC ACID

10% & 3% LIQUID

00510335	TARGEL SA	ODN

10% & 4% SHAMPOO

00666114	SEBCUR-T	DPT

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ACITRETIN

Open benefit (prior approval not required).

Soriatane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

ST **10MG CAPSULE**

02070847	SORIATANE	ACG

ST **25MG CAPSULE**

02070863	SORIATANE	ACG

ADAPALENE

0.1% CREAM

02231592	DIFFERIN	GAC

0.1% GEL

02148749	DIFFERIN	GAC

AZELAIC ACID

15% GEL

02270811	FINACEA	BAY

CALCIPOTRIOL

50MCG/G OINTMENT

01976133	DOVONEX	LEO

CAPSAICIN

0.025% CREAM

02157101	CAPSAICIN	VAE
02244952	ZODERM	EUR
00740306	ZOSTRIX	VAE

0.075% CREAM

02157128	CAPSAISIN	VAE
02004240	ZOSTRIX HP	VAE

COLLAGENASE

250U OINTMENT

02063670	SANTYL	SNE

FLUOROURACIL

5% CREAM

00330582	EFUDEX	VAE

IMIQUIMOD

Limited use benefit (prior approval required).

For the treatment of condylomata acuminate (genital warts) in patients who have failed:

- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

5% CREAM

02239505	ALDARA P	VAE
02407825	APO-IMIQUIMOD	APX

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

ISOTRETINOIN

Open benefit (prior approval not required).

Accutane should be used with caution in women of childbearing potential due to its teratogenicity. Pregnancy must be excluded. Effective contraception must be used. Manufacturer's literature regarding contraindications and warnings should be consulted prior to prescribing or dispensing this drug.

[ST] **10MG CAPSULE**

00582344	ACCUTANE ROCHE	HLR
02257955	CLARUS	MYL

[ST] **40MG CAPSULE**

00582352	ACCUTANE ROCHE	HLR
02257963	CLARUS	MYL

PIMECROLIMUS

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

1% CREAM

02247238	ELIDEL	VAE

PODOFILOX

0.5% SOLUTION

01945149	CONDYLINE	SAC

PODOPHYLLIN

25% LIQUID

00598208	PODOFILM	PAL

SECUKINUMAB

Limited use benefit (prior approval required).

- Psoriasis according to established criteria.

(Please refer to Appendix A).

150MG SOLUTION

02438070	COSENTYX	NVR

TACROLIMUS (PROTOPIC)

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

0.03% OINTMENT

02244149	PROTOPIC	LEO

0.1% OINTMENT

02244148	PROTOPIC	LEO

TAZAROTENE

0.05% CREAM

02243894	TAZORAC	ALL

0.1% CREAM

02243895	TAZORAC	ALL

0.05% GEL

02230784	TAZORAC	ALL

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

TAZAROTENE

0.1% GEL

02230785	TAZORAC	ALL

86:00 SMOOTH MUSCLE RELAXANTS

86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

1MG TABLET

02423308	MINT-TOLTERODINE	MIN

2MG TABLET

02423316	MINT-TOLTERODINE	MIN

86:12.04 ANTIMUSCARINICS

DARIFENACIN HYDROBROMIDE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

7.5MG TABLET (EXTENDED RELEASE)

02273217	ENABLEX	MRL

15MG TABLET (EXTENDED RELEASE)

02273225	ENABLEX	MRL

FESOTERODINE FUMARATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

4MG TABLET (EXTENDED RELEASE)

02380021	TOVIAZ	PFI

8MG TABLET (EXTENDED RELEASE)

02380048	TOVIAZ	PFI

FLAVOXATE HYDROCHLORIDE

200MG TABLET

00728179	URISPAS	PAL

OXYBUTYNIN CHLORIDE

1MG/ML SYRUP

02231089	APO-OXYBUTYNIN	APX
02223376	PMS-OXYBUTYNIN	PMS

2.5MG TABLET

02240549	PMS-OXYBUTYNIN	PMS

5MG TABLET

02163543	APO-OXYBUTYNIN	APX
02241285	DOM-OXYBUTYNIN	DPC
02350238	OXYBUTYNIN	SAN

86:12.04 ANTIMUSCARINICS

OXYBUTYNIN CHLORIDE

5MG TABLET

02220636	OXYBUTYNINE	PDL
02240550	PMS-OXYBUTYNIN	PMS
02299364	RIVA-OXYBUTYNIN	RIV
02230394	TEVA-OXYBUTYNIN	TEV

SOLIFENACIN SUCCINATE

5MG TABLET

02422239	ACT SOLIFENACIN	ACG
02446375	AURO-SOLIFENACIN	AUR
02424339	JAMP-SOLIFENACIN	JMP
02428911	MED-SOLIFENACIN	GMP
02443171	MINT-SOLIFENACIN	MIN
02417723	PMS-SOLIFENACIN	PMS
02437988	RAN-SOLIFENACIN	RBY
02399032	SANDOZ SOLIFENACIN	SDZ
02458144	SOLIFENACIN	PDL
02458241	SOLIFENACIN	SAN
02397900	TEVA-SOLIFENACIN	TEV
02277263	VESICARE	AST

10MG TABLET

02422247	ACT SOLIFENACIN	ACG
02446383	AURO-SOLIFENACIN	AUR
02424347	JAMP-SOLIFENACIN	JMP
02428938	MED-SOLIFENACIN	GMP
02443198	MINT-SOLIFENACIN	MIN
02417731	PMS-SOLIFENACIN	PMS
02437996	RAN-SOLIFENACIN	RBY
02399040	SANDOZ SOLIFENACIN	SDZ
02458152	SOLIFENACIN	PDL
02458268	SOLIFENACIN	SAN
02397919	TEVA-SOLIFENACIN	TEV
02277271	VESICARE	AST

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

2MG CAPSULE (EXTENDED RELEASE)

02244612	DETROL LA	PFI
02404184	MYLAN-TOLTERODINE ER	MYL
02413140	SANDOZ TOLTERODINE LA	SDZ
02412195	TEVA-TOLTERODINE LA	TEV

4MG CAPSULE (EXTENDED RELEASE)

02244613	DETROL LA	PFI
02404192	MYLAN-TOLTERODINE ER	MYL
02413159	SANDOZ TOLTERODINE LA	SDZ
02412209	TEVA-TOLTERODINE LA	TEV

1MG TABLET

02369680	APO-TOLTERODINE	APX
02239064	DETROL	PFI
02299593	TEVA-TOLTERODINE	TEV

86:12.04 ANTIMUSCARINICS

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **2MG TABLET**

02369699	APO-TOLTERODINE	APX
02239065	DETROL	PFI
02299607	TEVA-TOLTERODINE	TEV

TROSPIUM CHLORIDE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **20MG TABLET**

02275066	TROSEC	SPC

86:12.08 BETA-ADRENERGIC AGONISTS

MIRABEGRON

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **25MG TABLET (EXTENDED RELEASE)**

02402874	MYRBETRIQ	AST

ST **50MG TABLET (EXTENDED RELEASE)**

02402882	MYRBETRIQ	AST

86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS

OXTRIPHYLLINE

ST **20MG/ML ELIXIR**

00476366	CHOLEDYL	ERF

ST **100MG TABLET**

00441724	APO OXTRIPHYLLINE	APX

ST **200MG TABLET**

00441732	APO OXTRIPHYLLINE	APX

ST **300MG TABLET**

00511692	APO OXTRIPHYLLINE	APX

THEOPHYLLINE

ST **5.33MG/ML ELIXIR**

00466409	PULMOPHYLLINE	RIV
01966219	THEOLAIR	VAE
00627410	THEOPHYLLINE	ATL

ST **100MG TABLET (EXTENDED RELEASE)**

00692689	APO-THEO-LA	APX
02230085	TEVA-THEOPHYLLINE	TEV

86:16.00 RESPIRATORY SMOOTH MUSCLE RELAXANTS

THEOPHYLLINE

ST **200MG TABLET (EXTENDED RELEASE)**

00692697	APO-THEO-LA	APX
02230086	TEVA-THEOPHYLLINE	TEV

ST **300MG TABLET (EXTENDED RELEASE)**

00692700	APO-THEO-LA	APX
02230087	TEVA-THEOPHYLLINE	TEV

ST **400MG TABLET (EXTENDED RELEASE)**

02360101	THEO ER	AAP
02014165	UNIPHYL	PFR

ST **600MG TABLET (EXTENDED RELEASE)**

02360128	THEO ER	AAP
02014181	UNIPHYL	PFR

88:00 VITAMINS

88:04.00 VITAMIN A

VITAMIN A

10,000IU CAPSULE

80054130	JAMP-VITAMIN A	JMP
00297720	VITAMIN A	JAM
00557447	VITAMIN A	VTH

88:08.00 VITAMIN B COMPLEX

CYANOCOBALAMIN

100MCG/ML LIQUID

00497533	VITAMIN B12	HOS
02241500	VITAMIN B12	SDZ

200MCG/ML LIQUID

80039903	BEDUZIL	ORM
80026092	JAMP-VITAMIN B12	JMP

1,000MCG/ML LIQUID

00626112	B-12	OMG
01987003	CYANOCOBALAMIN	RAX
02052717	CYANOCOBALAMIN	TAR
02413795	CYANOCOBALAMIN	MYL
02420147	JAMP-CYANOCOBALAMIN	JMP
00038830	VITAMIN B12	HOS
00521515	VITAMIN B12	SDZ

1 TABLET

80015276	JAMP-VITAMIN B12	JMP
80055741	M-B12	MAN
02237736	VITAMIN B12	VAE

250MCG TABLET

80015294	JAMP-VITAMIN B12	JMP
80055743	M-B12	MAN
00335940	VITAMIN B12	JAM
02239695	VITAMIN B12	PMT
80004053	VITAMIN B12	WNP

1000MCG TABLET

80028902	JAMP VITAMIN B12	JMP
80003575	VITAMIN B12	PMT
80006939	VITAMIN B12	WNP

FOLIC ACID

1MG TABLET

00318973	FOLIC ACID	JAM
00647039	FOLIC ACID	VTH
02048841	FOLIC ACID	PMT
80000273	FOLIC ACID	WNP
80053274	JAMP FOLIC ACID	JMP
02236747	WAMPOLE FOLIC ACID	WAM

5MG TABLET

00426849	APO FOLIC ACID	APX
02285673	EURO-FOLIC	SDZ
02366061	JAMP-FOLIC ACID	JMP

1000MCG TABLET

02239882	FOLIC ACID	UNK

NIACIN

50MG TABLET

00041084	NIACIN	ADA

88:08.00 VITAMIN B COMPLEX

NIACIN

500MG TABLET

00309737	NIACIN	JAM
00557412	NIACIN	VTH
01939130	NIACIN	ODN
02247004	NIACIN	PMT

PYRIDOXINE HYDROCHLORIDE

25MG TABLET

80056458	M-B6	MAN
00122645	VITAMIN B6	JAM
00232475	VITAMIN B6	ADA
01943200	VITAMIN B6	ODN
80002890	VITAMIN B6	JMP

50MG TABLET

00305227	VITAMIN B6	JAM
00608599	VITAMIN B6	ADA

100MG TABLET

00450677	B6	VTH
00263958	VITAMIN B6	VAE
00329185	VITAMIN B6	JAM
02239348	VITAMIN B6	PMT

THIAMINE HYDROCHLORIDE

100MG/ML LIQUID

02241983	BETAXIN	HOS
02193221	THIAMIJECT	OMG
02243525	THIAMINE	RAX

100MG/ML SOLUTION

00816078	VITAMIN B1	SDZ

50MG TABLET

02245506	EURO VITAMIN B1	EUR
80054199	M-B1	MAN
00268631	THIAMINE	VAE
80009633	VITAMIN B1	JMP

100MG TABLET

80054205	M-B1	MAN
00232467	VITAMIN B1	PED
00407011	VITAMIN B1	JAM
02239350	VITAMIN B1	PMT
80000352	VITAMIN B1	WNP
80009588	VITAMIN B1	JMP

88:12.00 VITAMIN C

ASCORBIC ACID

500MG CAPLET

02163268	VITAMIN C	JAM

250MG TABLET

00162515	VITAMIN C	PMT
00221244	VITAMIN C	ADA
00266051	VITAMIN C	PMT
00557811	VITAMIN C	VTH

500MG TABLET

00266086	ASCORBIC ACID	PMT
00041114	VITAMIN C	ADA
00322326	VITAMIN C	ADA
00557838	VITAMIN C	VTH

88:12.00 VITAMIN C

ASCORBIC ACID

500MG TABLET

00784591	VITAMIN C	VTH
01922378	VITAMIN C	VAE
02243893	VITAMIN C	PMT
02244469	VITAMIN C	PMT
02245348	VITAMIN C	WNP
02245721	VITAMIN C	PMT
00322997	VITAMINE C	LAL
00036188	WAMPOLE VITAMIN C	WAM
00274240	WAMPOLE VITAMIN C	WAM

VITAMIN C

500MG TABLET

80003328	VITAMIN C	WNP

88:16.00 VITAMIN D

ALFACALCIDOL

0.25MCG CAPSULE

00474517	ONE ALPHA	LEO

1MCG CAPSULE

00474525	ONE ALPHA	LEO

2MCG/ML DROP

02240329	ONE-ALPHA	LEO

CALCITRIOL

0.25MCG CAPSULE

02431637	CALCITRIOL-ODAN	ODN
00481823	ROCALTROL	HLR

0.5MCG CAPSULE

02431645	CALCITRIOL-ODAN	ODN
00481815	ROCALTROL	HLR

CHOLECALCIFEROL

400IU CAPSULE

80006629	DGEL	JMP
02242651	EURO D	EUR
80005560	RIVA-D	RIV

800IU CAPSULE

80007769	DGEL	JMP

1,000IU CAPSULE

80027592	DGEL	OPU
80009635	VITAMIN D3	WAM

10,000IU CAPSULE

02253178	EURO D	SDZ

50,000IU CAPSULE

02301911	OSTO-D2	PAL

400IU LIQUID

80001869	BABY DDROPS	DDP
80001792	DDROPS	DDP

400IU/ML LIQUID

00762881	D VI INFANTS	MJO
80003038	JAMP VITAMIN D	JMP
02231624	PEDIAVIT D	EUR

1,000IU LIQUID

80001791	DDROPS	DDP

88:16.00 VITAMIN D

CHOLECALCIFEROL

400IU TABLET

02238729	VITAMIN D	VTH
02240858	VITAMIN D	PMT
00765384	VITAMINE D	LAL
02240624	WAMPOLE VITAMIN D	WAM

1,000IU TABLET

02245842	VITAMIN D3	PMT

10,000IU TABLET

00821772	D-TABS	RIV
02417995	VITAMINE D	PDL

ERGOCALCIFEROL

50,000IU CAPSULE

02237450	D-FORTE	SDZ

8 ORAL LIQUID

02017598	DRISDOL	SAC

8,288IU/ML ORAL LIQUID

80003615	ERDOL	ODN

8,288IU/ML SOLUTION

80020776	D2-DOL	JMP

VITAMIN D

1 CAPSULE

80063899	VIT D 1000	UNK

10MCG CAPSULE

80063895	VIT D 400	UNK

200U CAPSULE

02442256	VITAMIN D3	ORM

400IU CAPSULE

80055196	M-D	MAN
80001145	PHARMA-D	PED
80008590	VITAMINE D	BMI

800IU CAPSULE

80003010	EURO D	EUR
80008446	VITAMINE D	BMI

1,000IU CAPSULE

80007766	DGEL	JMP
80003707	EURO-D	EUR
80055204	M-D	MAN
80008496	PHARMA-D	PMS
80043412	VITAMINE D	BMI

10,000IU CAPSULE

02449099	JAMP-VITAMIN D	JMP
02371499	PHARMA-D	PMS

400IU LIQUID

80038155	DECAXIL	ORM
80041145	DECAXIL	ORM

1,000IU LIQUID

80007346	JAMP VITAMIN D	JMP
80028362	JAMP VITAMIN D	JMP
80028371	JAMP VITAMIN D	JMP

400IU ORAL LIQUID

80019649	D3-DOL	JMP

800IU ORAL LIQUID

80003285	PEDIAVIT D	EUR

88:16.00 VITAMIN D

VITAMIN D

ST **25MCG TABLET**

80031157	VITAMIN D	WNP

ST **400IU TABLET**

80002452	VITAMIN D	WNP
80009578	VITAMIN D	VAE

ST **1,000IU TABLET**

80002169	PHARMA-D	PMS
80051562	RIVA-D	RIV
80000131	VITAMIN D	VTH
80000436	VITAMIN D	JAM
80003663	VITAMIN D	WNP
80009580	VITAMIN D	VAE
80015278	WAMPOLE VITAMIN D	WAM

ST **10,000IU TABLET**

02379007	JAMP-VITAMIN D	JMP
02417685	VIDEXTRA	ORM

88:20.00 VITAMIN E

VITAMIN E

Limited use benefit (prior approval required).

For use in malabsorption

ST **100IU CAPSULE**

00122823	VITAMIN E	JAM

ST **200IU CAPSULE**

00122831	VITAMIN E	JAM

ST **400IU CAPSULE**

00122858	VITAMIN E	JAM

ST **800IU CAPSULE (SOFTGEL)**

00330191	VITAMIN E	JAM

ST **50IU ORAL LIQUID**

00480215	AQUASOL E	NVC

ST **50IU/ML ORAL LIQUID**

02162075	AQUASOL E VITAMIN E	CLC

88:24.00 VITAMIN K

PHYTONADIONE

2MG/ML EMULSION

00781878	VITAMIN K1	SDZ

10MG/ML EMULSION

00804312	VITAMIN K1	SDZ

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PEDIATRIC)

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

ST **DROP**

00762946	ENFAMIL POLYVISOL	MJO

ST **450MG & 10MG & 30MG LIQUID**

80008471	JAMP VITAMIN A, D AND C	JMP

ST **2,500IU & 666.67IU & 50MG/ML LIQUID**

00762903	ENFAMIL TRIVISOL	MJO
02229790	PEDIAVIT	EUR

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PEDIATRIC)

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

ST **TABLET (CHEWABLE)**

80011134	CENTRUM JUNIOR COMPLETE	PFI
80020794	CENTRUM JUNIOR COMPLETE	PFI
02247995	FLINTSTONES MULTIPLE VITAMINS PLUS IRON	BAY
02247975	FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C	BAY

MULTIVITAMINS (PRENATAL)

Limited use benefit (prior approval is not required.).

Prenatal and postnatal vitamins are benefits only for women of childbearing age (12 to 50 years).

ST **TABLET**

80042704	CENTRUM DHA	PFI
80045822	CENTRUM PRENATAL	PFI
80001842	NESTLÉ MATERNA	NES
02241235	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	VTH
80005770	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	PMT
02229535	WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	WAM

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EXTEMPORANEOUS MIXTURE

CAPSULE

99505003	PHENAZOPYRIDINE COMPOUNDED	UNK

CREAM

99500000	HYDROCORTISONE POWDER AND CLOTRIMAZOLE CREAM	UNK
99500010	LCD IN CORTICOSTEROID CREAM	UNK
99500009	LCD IN NON-MEDICATED CREAM	UNK
99500002	MENTHOL &/OR CAMPHOR IN STEROID	UNK
99500004	MISCELLANEOUS COMPOUNDED TOPICAL CREAM	UNK
99500001	STEROID AND ANTIFUNGAL CREAM	UNK
99500006	SULFUR IN NON-MEDICATED CREAM	UNK

INJECTION

99506021	MISCELLANEOUS COMPOUNDED INJECTION/INFUSION	UNK

LOTION

99502001	MENTHOL & CAMPHOR IN CORTICOSTEROID LOTION	UNK
99502002	MISCELLANEOUS COMPOUNDED EXTERNAL LOTION	UNK

MISCELLANEOUS

00915000	STERILE EXTEMPORANEOUS MIXTURE (QC)	UNK

OINTMENT

99501006	ALL PURPOSE NIPPLE OINTMENT	UNK
99501003	CALCIUM CHANNEL BLOCKER IN OINTMENT	UNK
99501000	LCD IN CORTICOSTEROID OINTMENT	UNK
99501005	LCD IN NON-MEDICATED OINTMENT	UNK
99501004	MISCELLANEOUS COMPOUNDED TOPICAL OINTMENT	UNK
99501002	SULFUR IN NON-MEDICATED OINTMENT	UNK

OPHTHALMIC AND OTIC SOLUTION

99507000	MISCELLANEOUS COMPOUNDED EYE/EAR DROP	UNK

ORAL LIQUID

99503028	ANTACID AND LIDOCAINE ORAL LIQUID	UNK
99503029	MAGIC MOUTHWASH	UNK
99503025	MISCELLANEOUS COMPOUNDED INTERNAL LIQUID	UNK

POWDER

99504000	MISCELLANEOUS COMPOUNDED EXTERNAL POWDER	UNK
99505000	MISCELLANEOUS COMPOUNDED INTERNAL POWDER	UNK

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EXTEMPORANEOUS MIXTURE

SUPPOSITORY

99508000	MISCELLANEOUS COMPOUNDED SUPPOSITORY	UNK

EXTEMPORANEOUS MIXTURE (LU)

Limited use benefit (prior approval required).

MISCELLANEOUS

99504001	MISC LIMITED USE EXTERNAL COMPOUND MIXTURE	UNK

ORAL LIQUID

99503033	MISC LIMITED USE COMPOUND INTERNAL	UNK
99503032	OPIOID COMPOUNDED	UNK

GOSERELIN ACETATE

10.8MG/DEPOT IMPLANT

02225905	ZOLADEX LA	UNK

OCTREOTIDE ACETATE

10MG/VIAL POWDER

02239323	SANDOSTATIN LAR	NVR

20MG/VIAL POWDER

02239324	SANDOSTATIN LAR	NVR

30MG/VIAL POWDER

02239325	SANDOSTATIN LAR	NVR

50MCG/ML SOLUTION

02413191	OCPHYL	PED
02248639	OCTREOTIDE ACETATE OMEGA	OMG
00839191	SANDOSTATIN	NVR

100MCG/ML SOLUTION

02413205	OCPHYL	PED
02248640	OCTREOTIDE ACETATE OMEGA	OMG
00839205	SANDOSTATIN	NVR

200MCG/ML SOLUTION

02248642	OCTREOTIDE ACETATE OMEGA	OMG
02049392	SANDOSTATIN	NVR

500MCG SOLUTION

02299453	OCTREOTIDE	TEV

500MCG/ML SOLUTION

02413213	OCPHYL	PED
02248641	OCTREOTIDE ACETATE OMEGA	OMG
00839213	SANDOSTATIN	NVR

PENTOSAN POLYSULFATE SODIUM

100MG CAPSULE

02029448	ELMIRON	JSO

USTEKINUMAB

Limited use benefit (prior approval required).

- Psoriasis according to established criteria.

(Please refer to Appendix A).

45MG/0.5ML SOLUTION

02320673	STELARA	JSO

90MG/ML SOLUTION

02320681	STELARA	JSO

92:01.00 NATURAL HEALTH PRODUCTS

FOLIC ACID

1MG TABLET

80061488	M-FOLIQUE	MAN

92:01.40

CALCIUM

500MG TABLET

80076097	CALCIUM	UNK

92:05.00 SERUMS

APIS MELLIFERA VENOM PROTEIN EXTRACT

1.1MG POWDER FOR SOLUTION

01948903	PHARMALGEN HONEY BEE VENOM	ALK

120MCG POWDER FOR SOLUTION

01948911	PHARMALGEN HONEY BEE VENOM	ALK

DOLICHOVESPULA ARENARIA VENOM PROTEIN

120MCG POWDER FOR SOLUTION

01948946	PHARMALGEN YELLOW HORNET VENOM PROTEIN	ALK

DOLICHOVESPULA MACULATA VENOM PROTEIN EXTRACT

120MCG POWDER FOR SOLUTION

01949004	PHARMALGEN WHITE FACED HORNET VENOM	ALK

HONEY BEE VENOM PROTEIN EXTRACT

120MCG POWDER FOR SOLUTION

02226197	VENOMIL HONEY BEE VENOM	JUB

550MCG POWDER FOR SOLUTION

02220075	HYMENOPTERA VENOM PRODUCT HONEY BEE VENOM	JUB

NON POLLEN

100,000U LIQUID

00299979	ALLERGENIC EXTRACT NON POLLENS	ALK
00514713	ALLERGENIC EXTRACTS	MSL

POLISTES SPP VENOM PROTEIN EXTRACT

1.1MG POWDER FOR SOLUTION

01948970	PHARMALGEN WASP VENOM PROTEIN	ALK

POLLEN

4,300U/ML LIQUID

00464988	POLLINEX R	BEN

100,000U LIQUID

00299987	ALLERGENIC EXTRACT POLLENS	ALK

POLLEN AND NON POLLEN

20,000U LIQUID

00648922	CENTER-AL	ALK

VENOM PROTEIN EXTRACT

3,300MCG POWDER FOR SOLUTION

01948873	PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK

92:05.00 SERUMS

VESPULA SPP VENOM PROTEIN EXTRACT

1.1MG POWDER FOR SOLUTION

01948954	PHARMALGEN YELLOW JACKET VENOM PROTEIN	ALK

120MCG POWDER FOR SOLUTION

01948962	PHARMALGEN YELLOW JACKET VENOM PROTEIN	ALK

WASP VENOM PROTEIN

120MCG POWDER FOR SOLUTION

02226219	VENOMIL WASP VENOM PROTEIN	JUB

550MCG POWDER FOR SOLUTION

02220091	HYMENOPTERA VENOM PRODUCT WASP VENOM PROTEIN	JUB

WHITE FACED HORNET VENOM PROTEIN

120MCG POWDER FOR SOLUTION

02226235	VENOMIL WHITE-FACED HORNET VENOM PROTEIN	JUB

WHITE FACED HORNET VENOM PROTEIN, YELLOW HORNET VENOM PROTEIN, YELLOW JACKET VENOM PROTEIN

120MCG POWDER FOR SOLUTION

01948881	PHARMALGEN MIXED VESPID VENOM PROTEIN	ALK
02226294	VENOMIL MIXED VESPID VENOM PROTEIN	JUB

550MCG POWDER FOR SOLUTION

02221314	HYMENOPTERA VENOM PRODUCT MIXED VESPID VENOM PROTEIN	JUB

YELLOW HORNET VENOM PROTEIN

120MCG/ML POWDER FOR SOLUTION

02226251	VENOMIL YELLOW HORNET VENOM PROTEIN	JUB

550MCG POWDER FOR SOLUTION

02220083	HYMENOPTERA VENOM PRODUCTS YELLOW HORNET VENOM PROTEIN	JUB

YELLOW JACKET VENOM PROTEIN

120MCG POWDER FOR SOLUTION

02226286	VENOMIL YELLOW JACKET VENOM PROTEIN	JUB

550MCG POWDER FOR SOLUTION

02220113	HYMENOPTERA VENOM PRODUCT YELLOW JACKET VENOM PROTEIN	JUB

92:08.00 5 ALFA REDUCTASE INHIBITORS

DUTASTERIDE

Limited use benefit (prior approval required).

For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an adrenergic blocker.
OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

0.5MG CAPSULE

02412691	ACT DUTASTERIDE	ACG
02404206	APO-DUTASTERIDE	APX
02247813	AVODART	GSK
02421712	DUTASTERIDE	PDL
02429012	DUTASTERIDE	SIV
02443058	DUTASTERIDE	SAN
02416298	MED-DUTASTERIDE	GMP
02428873	MINT-DUTASTERIDE	MIN
02393220	PMS-DUTASTERIDE	PMS
02427753	RIVA-DUTASTERIDE	RIV
02424444	SANDOZ DUTASTERIDE	SDZ
02408287	TEVA-DUTASTERIDE	TEV

FINASTERIDE

Limited use benefit (prior approval required).

For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an alpha-adrenergic blocker.
OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

5MG TABLET

02355043	ACH-FINASTERIDE	ACC
02354462	ACT FINASTERIDE	ACG
02365383	APO-FINASTERIDE	APX
02405814	AURO-FINASTERIDE	AUR
02376709	DOM-FINASTERIDE	DPC
02350270	FINASTERIDE	PDL
02445077	FINASTERIDE	SAN
02447541	FINASTERIDE	SIV
02357224	JAMP-FINASTERIDE	JMP
02389878	MINT-FINASTERIDE	MIN
02310112	PMS-FINASTERIDE	PMS
02010909	PROSCAR	FRS
02371820	RAN-FINASTERIDE	RBY
02306905	RATIO-FINASTERIDE	TEV
02455013	RIVA-FINASTERIDE	RIV
02322579	SANDOZ FINASTERIDE	SDZ
02348500	TEVA-FINASTERIDE	TEV
02428741	VAN-FINASTERIDE	VAN

92:12.00 ANTIDOTES

LEUCOVORIN CALCIUM

5MG TABLET

02170493	LEDERLE LEUCOVORIN	PFI

92:16.00 ANTIGOUT AGENTS

ALLOPURINOL

100MG TABLET

00555681	ALLOPURINOL	PDL
02402769	APO-ALLOPURINOL	APX
02421593	JAMP-ALLOPURINOL	JMP
02396327	MAR-ALLOPURINOL	MAR
00402818	ZYLOPRIM	AAP

200MG TABLET

02130157	ALLOPURINOL	PDL
02402777	APO-ALLOPURINOL	APX
02421607	JAMP-ALLOPURINOL	JMP
02396335	MAR-ALLOPURINOL	MAR
00479799	ZYLOPRIM	AAP

300MG TABLET

00294322	ALLOPURINOL	APX
00555703	ALLOPURINOL	PDL
02402785	APO-ALLOPURINOL	APX
02421615	JAMP-ALLOPURINOL	JMP
02396343	MAR-ALLOPURINOL	MAR
00402796	ZYLOPRIM	AAP

PDIN FOR EXTEMPORANEOUS MIXTURE

99503018	ALLOPURINOL ORAL LIQUID	UNK

COLCHICINE

0.6MG TABLET

00572349	COLCHICINE	ODN
02373823	JAMP-COLCHICINE	JMP
02402181	PMS-COLCHICINE	PMS
00287873	SANDOZ COLCHICINE	SDZ

FEBUXOSTAT

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

80MG TABLET

02357380	ULORIC	TAK

92:24.00 BONE RESORPTION INHIBITORS

ALENDRONATE SODIUM

5MG TABLET

02381478	ACH-ALENDRONATE	ACC
02248727	APO-ALENDRONATE	APX
02384698	RAN-ALENDRONATE	RBY
02248251	TEVA-ALENDRONATE	TEV
02428717	VAN-ALENDRONATE	VAN

10MG TABLET

02381486	ACH-ALENDRONATE	ACC
02248728	APO-ALENDRONATE	APX
02388545	AURO-ALENDRONATE	AUR
02394863	MINT-ALENDRONATE	MIN
02384701	RAN-ALENDRONATE	RBY
02288087	SANDOZ ALENDRONATE	SDZ
02247373	TEVA-ALENDRONATE	TEV
02428725	VAN-ALENDRONATE	VAN

40MG TABLET

02258102	ACT ALENDRONATE	ACG

92:24.00 BONE RESORPTION INHIBITORS

ALENDRONATE SODIUM

ST **70MG TABLET**

02381494	ACH-ALENDRONATE	ACC
02258110	ACT ALENDRONATE	ACG
02299712	ALENDRONATE	SIV
02352966	ALENDRONATE	SAN
02303078	ALENDRONATE-70	PDL
02248730	APO-ALENDRONATE	APX
02388553	AURO-ALENDRONATE	AUR
02282763	DOM-ALENDRONATE	DPC
02245329	FOSAMAX	FRS
02385031	JAMP-ALENDRONATE	JMP
02394871	MINT-ALENDRONATE	MIN
02286335	MYLAN-ALENDRONATE	MYL
02273179	PMS-ALENDRONATE	PMS
02284006	PMS-ALENDRONATE	PMS
02384728	RAN-ALENDRONATE	RBY
02270889	RIVA-ALENDRONATE	RIV
02288109	SANDOZ ALENDRONATE	SDZ
02261715	TEVA-ALENDRONATE	TEV
02428733	VAN-ALENDRONATE	VAN

ALENDRONATE SODIUM, CHOLECALCIFEROL

ST **70MG & 2,800U TABLET**

02454467	APO-ALENDRONATE/VITAMIN D3	APX
02276429	FOSAVANCE	FRS
02403633	TEVA-ALENDRONATE/CHOLECALCIFEROL	TEV

ST **70MG & 5,600U TABLET**

02454475	APO-ALENDRONATE/VITAMIN D3	APX
02314940	FOSAVANCE	FRS
02429160	SANDOZ ALENDRONATE/CHOLECALCIFEROL	SDZ
02403641	TEVA-ALENDRONATE/CHOLECALCIFEROL	TEV

DENOSUMAB (PROLIA)

Limited use benefit (prior approval required).

For women with postmenopausal osteoporosis who have failed or have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);

AND who have at least two of the following:
- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score ≤ -2.5

Maximum dose covered is 60mg per 6-month period.

60MG/ML SOLUTION

02343541	PROLIA	AMG

92:24.00 BONE RESORPTION INHIBITORS

DENOSUMAB (XGEVA)

Limited use benefit (prior approval required).

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with:
- one or more documented bone metastases; AND
- good performance status (ECOG performance status score of 0, 1, or 2).

120MG/1.7ML SOLUTION

02368153	XGEVA	AMG

ETIDRONATE DISODIUM

ST **200MG TABLET**

02248686	ACT ETIDRONATE	ACG

ETIDRONATE DISODIUM, CALCIUM CARBONATE

ST **400MG & 500MG TABLET**

02263866	ACT ETIDROCAL	ACG
02324199	NOVO-ETIDRONATECAL	TEV

PAMIDRONATE DISODIUM

6MG SOLUTION

02249677	PAMIDRONATE	OMG

9MG SOLUTION

02246599	PAMIDRONATE	FKD

30MG SOLUTION

02264951	PAMIDRONATE	SDZ
02244550	PAMIDRONATE DISODIUM	PFI

60MG SOLUTION

02264978	PAMIDRONATE	SDZ
02244551	PAMIDRONATE DISODIUM	PFI

90MG SOLUTION

02264986	PAMIDRONATE	SDZ
02244552	PAMIDRONATE DISODIUM	PFI
02245999	PMS-PAMIDRONATE	PMS

RISEDRONATE SODIUM

ST **5MG TABLET**

02242518	ACTONEL	WAC
02298376	TEVA-RISEDRONATE	TEV

ST **30MG TABLET**

02239146	ACTONEL	ALL
02298384	TEVA-RISEDRONATE	TEV

ST **35MG TABLET**

02246896	ACTONEL	ALL
02353687	APO-RISEDRONATE	APX
02406306	AURO-RISEDRONATE	AUR
02309831	DOM-RISEDRONATE	DPC
02368552	JAMP-RISEDRONATE	JMP
02302209	PMS-RISEDRONATE	PMS
02347474	RISEDRONATE	PDL
02352141	RISEDRONATE	SIV
02370255	RISEDRONATE	SAN
02411407	RISEDRONATE-35	SIV
02341077	RIVA-RISEDRONATE	RIV
02327295	SANDOZ RISEDRONATE	SDZ
02298392	TEVA-RISEDRONATE	TEV

ST **150MG TABLET**

02316838	ACTONEL	ALL

92:24.00 BONE RESORPTION INHIBITORS

RISEDRONATE SODIUM

150MG TABLET

02377721	APO-RISEDRONATE	APX
02424177	PMS-RISEDRONATE	PMS
02413809	TEVA-RISEDRONATE	TEV

ZOLEDRONIC ACID MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of Paget's disease. Coverage will be granted for one dose per 12 month period;
OR
For women with postmenopausal osteoporosis who would otherwise be eligible for coverage of oral bisphosphonates, but who have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);
AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score ≤ - 2.5.

5MG/100ML SOLUTION

02269198	ACLASTA	NVR
02415100	TARO-ZOLEDRONIC ACID	TAR
02408082	ZOLEDRONIC ACID	TEV
02422433	ZOLEDRONIC ACID	REC

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ABATACEPT

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

250MG POWDER FOR SOLUTION

02282097	ORENCIA	BMS

125MG SOLUTION

02402475	ORENCIA	BMS

ADALIMUMAB

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Psoriasis according to established criteria.
- Crohn's disease according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

40MG/VIAL SOLUTION

02258595	HUMIRA	ABV

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

CERTOLIZUMAB PEGOL

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic arthritis according to established criteria.
- Ankylosing spondylitis according to established criteria.

(Please refer to Appendix A).

200MG SOLUTION

02465574	CIMZIA	UCB

200MG/ML SOLUTION

02331675	CIMZIA	UCB

ETANERCEPT

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

25MG/VIAL INJECTION

02242903	ENBREL	PED

50MG/ML INJECTION

02274728	ENBREL	PED
99100373	ENBREL SURECLICK	AMG

ETANERCEPT (BRENZYS)

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.

(Please refer to Appendix A).

50MG SOLUTION

02455323	BRENZYS	UNK
02455331	BRENZYS	UNK

GOLIMUMAB

Limited use benefit (prior approval required).

For the treatment of:

- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

50MG/0.5ML SOLUTION

02324776	SIMPONI	JSO
02324784	SIMPONI	JSO

100MG/ML SOLUTION

02413175	SIMPONI	JSO
02413183	SIMPONI	JSO

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

INFLIXIMAB (INFLECTRA)

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.
- Psoriatic Arthritis according to established criteria.
- Ankylosing Spondylitis according to established criteria.
- Psoriasis according to established criteria.
- Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

100MG POWDER FOR SOLUTION

02419475	INFLECTRA	HOS

INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.
- Crohn's disease according to established criteria.
- Fistulizing Crohn's disease according to established criteria.

(Please refer to Appendix A).

100MG/VIAL POWDER FOR SOLUTION

02244016	REMICADE	JSO

LEFLUNOMIDE

ST **10MG TABLET**

02256495	APO-LEFLUNOMIDE	APX
02241888	ARAVA	SAC
02351668	LEFLUNOMIDE	SAN
02415828	LEFLUNOMIDE	PDL
02288265	PMS-LEFLUNOMIDE	PMS
02283964	SANDOZ LEFLUNOMIDE	SDZ
02261251	TEVA-LEFLUNOMIDE	TEV

ST **20MG TABLET**

02256509	APO-LEFLUNOMIDE	APX
02241889	ARAVA	SAC
02351676	LEFLUNOMIDE	SAN
02415836	LEFLUNOMIDE	PDL
02288273	PMS-LEFLUNOMIDE	PMS
02283972	SANDOZ LEFLUNOMIDE	SDZ
02261278	TEVA-LEFLUNOMIDE	TEV

TOCILIZUMAB (IV)

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.
- Systemic juvenile idiopathic arthritis (sJIA) according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

80MG/4ML SOLUTION

02350092	ACTEMRA	HLR

200MG/10ML SOLUTION

02350106	ACTEMRA	HLR

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

TOCILIZUMAB (IV)

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.
- Systemic juvenile idiopathic arthritis (sJIA) according to established criteria.
- Polyarticular juvenile idiopathic arthritis (pJIA) according to established criteria.

(Please refer to Appendix A).

400MG/20ML SOLUTION

02350114	ACTEMRA	HLR

TOCILIZUMAB (SC)

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A).

162MG SOLUTION

02424770	ACTEMRA	HLR

TOFACITINIB CITRATE

Limited use benefit (prior approval required).

For the treatment of:
- Rheumatoid Arthritis according to established criteria.

(Please refer to Appendix A).

5MG TABLET

02423898	XELJANZ	PFI

92:44.00 IMMUNOSUPPRESSIVE AGENTS

AZATHIOPRINE

ST **50MG TABLET**

02242907	APO-AZATHIOPRINE	APX
02243371	AZATHIOPRINE-50	PDL
00004596	IMURAN	ASP
02236819	TEVA-AZATHIOPRINE	TEV

ST **PDIN FOR EXTEMPORANEOUS MIXTURE**

99503019	AZATHIOPRINE ORAL LIQUID	UNK

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST **10MG CAPSULE**

02237671	NEORAL	NVR

ST **25MG CAPSULE**

02150689	NEORAL	NVR
02247073	SANDOZ CYCLOSPORINE	SDZ

ST **50MG CAPSULE**

02150662	NEORAL	NVR
02247074	SANDOZ CYCLOSPORINE	SDZ

ST **100MG CAPSULE**

02150670	NEORAL	NVR
02242821	SANDOZ CYCLOSPORINE	SDZ

92:44.00 IMMUNOSUPPRESSIVE AGENTS

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST **100MG/ML SOLUTION**

02244324	APO-CYCLOSPORINE	APX
02150697	NEORAL	NVR

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

ST **250MG CAPSULE**

02383780	ACH-MYCOPHENOLATE	ACC
02352559	APO-MYCOPHENOLATE	APX
02192748	CELLCEPT	HLR
02386399	JAMP-MYCOPHENOLATE	JMP
02457369	MYCOPHENOLATE MOFETIL	SAN
02371154	MYLAN-MYCOPHENOLATE	MYL
02320630	SANDOZ MYCOPHENOLATE	SDZ
02364883	TEVA-MYCOPHENOLATE	TEV
02433680	VAN-MYCOPHENOLATE	VAN

ST **500MG TABLET**

02352567	APO-MYCOPHENOLATE	APX
02237484	CELLCEPT	HLR
02380382	JAMP-MYCOPHENOLATE	JMP
02378574	MYCOPHENOLATE	ACC
02457377	MYCOPHENOLATE MOFETIL	SAN
02370549	MYLAN-MYCOPHENOLATE	MYL
02313855	SANDOZ MYCOPHENOLATE	SDZ
02348675	TEVA-MYCOPHENOLATE	TEV
02432625	VAN-MYCOPHENOLATE	VAN

MYCOPHENOLATE SODIUM

Limited use benefit (prior approval required).

For transplant therapy.

ST **180MG TABLET (ENTERIC COATED)**

02372738	APO-MYCOPHENOLIC ACID	APX
02264560	MYFORTIC	NVR

ST **360MG TABLET (ENTERIC COATED)**

02372746	APO-MYCOPHENOLIC ACID	APX
02264579	MYFORTIC	NVR

SIROLIMUS

Limited use benefit (prior approval required).

Coverage will be provided as a second line therapy for patients failing mycophenolate mofetil.

ST **1MG/ML SOLUTION**

02243237	RAPAMUNE	PFI

ST **1MG TABLET**

02247111	RAPAMUNE	PFI

TACROLIMUS MONOHYDRATE

Limited use benefit (prior approval required).

For transplant therapy.

ST **0.5MG CAPSULE**

02243144	PROGRAF	AST

92:44.00 IMMUNOSUPPRESSIVE AGENTS

TACROLIMUS MONOHYDRATE

Limited use benefit (prior approval required).

For transplant therapy.

ST **0.5MG CAPSULE**

02416816	SANDOZ TACROLIMUS	SDZ

ST **1MG CAPSULE**

02175991	PROGRAF	AST
02416824	SANDOZ TACROLIMUS	SDZ

ST **5MG CAPSULE**

02175983	PROGRAF	AST

ST **0.5MG CAPSULE (EXTENDED RELEASE)**

02296462	ADVAGRAF	AST

ST **1MG CAPSULE (EXTENDED RELEASE)**

02296470	ADVAGRAF	AST

ST **3MG CAPSULE (EXTENDED RELEASE)**

02331667	ADVAGRAF	AST

ST **5MG CAPSULE (EXTENDED RELEASE)**

02296489	ADVAGRAF	AST

ST **5MG CAPSULE (IMMEDIATE RELEASE)**

02416832	SANDOZ TACROLIMUS	SDZ

5MG/ML SOLUTION

02176009	PROGRAF	AST

VEDOLIZUMAB

Limited use benefit (prior approval required).

For the treatment of:
- Crohn's disease according to established criteria.
- Ulcerative colitis according to established criteria.

(Please refer to Appendix A).

300MG POWDER FOR SOLUTION

02436841	ENTYVIO	TAK

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

CYPROTERONE ACETATE

50MG TABLET

00704431	ANDROCUR	BAY
02245898	CYPROTERONE	AAP
02390760	MED-CYPROTERONE	GMP
02395797	RIVA-CYPROTERONE	RIV

CYPROTERONE ACETATE, ETHINYL ESTRADIOL

2MG & 35MCG TABLET

02290308	CYESTRA-35	PAL
02233542	DIANE-35	BAY
02309556	NOVO-CYPROTERONE/ETHINYL ESTRADIOL	TEV
02425017	RAN-CYPROTERONE/ETHINYL ESTRADIOL	RBY

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

INCOBOTULINUMTOXINA

Limited use benefit (prior approval required).

For the treatment of:
- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis).

50UNIT/VIAL POWDER FOR SOLUTION

02371081	XEOMIN	MEZ

100U/VIAL POWDER FOR SOLUTION

02324032	XEOMIN	MEZ

LANREOTIDE ACETATE

60MG/0.3ML SOLUTION (EXTENDED RELEASE)

02283395	SOMATULINE AUTOGEL	IPS

90MG/0.3ML SOLUTION (EXTENDED RELEASE)

02283409	SOMATULINE AUTOGEL	IPS

120MG/0.5ML SOLUTION (EXTENDED RELEASE)

02283417	SOMATULINE AUTOGEL	IPS

ONABOTULINUMTOXINA

Limited use benefit (prior approval required).

For the treatment of:
- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis); OR
- urinary incontinence due to neurogenic detrusor over activity resulting from neurogenic bladder associated with MS or subcervical spinal cord injury.

50IU INJECTION

09857386	BOTOX	ALL

200IU INJECTION

09857387	BOTOX	ALL

100IU POWDER FOR SOLUTION

01981501	BOTOX	ALL

94:00 DEVICES

94:00.00 DEVICES

SPACER DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

DEVICE

96899962	AEROCHAMBER AC BOYZ	TRU
96899963	AEROCHAMBER AC GIRLZ	TRU
96899969	AEROCHAMBER PLUS FLOWVU LARGE	TRU
96899970	AEROCHAMBER PLUS FLOWVU MEDIUM	TRU
96899968	AEROCHAMBER PLUS FLOWVU MOUTH	TRU
96899971	AEROCHAMBER PLUS FLOWVU SMALL	TRU
96899977	AEROTRACH PLUS	UNK
96899956	COMPACT SPACE PLUS LARGE MASK	MIN
96899955	COMPACT SPACE PLUS MEDIUM MASK	MIN
96899953	COMPACT SPACE PLUS NO MASK	MIN
96899954	COMPACT SPACE PLUS SMALL MASK	MIN
99400507	E-Z SPACER	WEP
99400511	E-Z SPACER (MASK ONLY)	WEP
99400508	E-Z SPACER WITH SMALL MASK	WEP
99400501	OPTICHAMBER	AUC
96899961	OPTICHAMBER DIAMOND (CHAMBER)	AUC
96899958	OPTICHAMBER DIAMOND LARGE MASK	AUC
96899959	OPTICHAMBER DIAMOND MEDIUM MASK	AUC
96899960	OPTICHAMBER DIAMOND SMALL MASK	AUC
99400504	OPTICHAMBER LARGE MASK	AUC
99400503	OPTICHAMBER MEDIUM MASK	AUC
99400502	OPTICHAMBER SMALL MASK	AUC
99400505	OPTIHALER	AUC
99400787	POCKET CHAMBER	MCA
99400791	POCKET CHAMBER WITH ADULT MASK	MCA
99400788	POCKET CHAMBER WITH INFANT MASK	MCA
99400790	POCKET CHAMBER WITH MEDIUM MASK	MCA
99400789	POCKET CHAMBER WITH SMALL MASK	MCA
96899974	RESPICHAMBER SILICONE MEDIUM MASK	TRU
96899973	RESPICHAMBER SILICONE SMALL MASK	TRU
96899972	RESPICHAMBER VHC W MOUTHPIECE	TRU

94:01.00 DEVICES (DIABETIC)

ADHESHIVE WIPES

MISCELLANEOUS

97799671	SKIN PREP ADHESHIVE WIPES	UNK

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

DEVICE

97799674	CARTRIDGE FOR IR200	UNK
97799342	INSET 30 INFUSION SETS	UNK
99401038	INSULIN PUMP BATTERY	AUC
09991458	IV3000	SMW

COMFORT ANGLED DEVICE

97799682	COMFORT ANGLED INFSET 17MM	UNK
97799683	COMFORT ANGLED INFSET 17MM	UNK

COMFORT SHORT ANGLED DEVICE

97799678	COMFORT SRT ANGLED INFSET 13	UNK
97799679	COMFORT SRT ANGLED INFSET 13	UNK

CONTACT DETACH DEVICE

97799672	CONTACT DETACH 90 DEGREE 6MMX60CM	UNK
97799610	CONTACT DETACH 90 DEGREE 8MMX60CM	UNK

INSET II DEVICE

97799685	INSET II 90 DEGREE 6MMX110CM	UNK
97799687	INSET II 90 DEGREE 6MMX60CM	UNK
97799684	INSET II 90 DEGREE 9MMX110CM	UNK
97799686	INSET II 90 DEGREE 9MMX60CM	UNK

MIO DEVICE

97799491	MIO BLUE 6MMX18	MDT
97799438	MIO BLUE 6MMX23	MDT
97799490	MIO CLEAR 6MMX32	MDT
97799489	MIO CLEAR 9MMX32	MDT
97799492	MIO PINK 6MMX18	MDT
97799437	MIO PINK 6MMX23	MDT

OMNIPOD DEVICE

09991327	PODS	UNK

PARADIGM SILHOUETTE DEVICE

97799715	PARADIGM SILHOUETTE 13MMX 43	MDT
97799485	PARADIGM SILHOUETTE 13MMX18"	MDT
97799716	PARADIGM SILHOUETTE 13MMX23	MDT
97799484	PARADIGM SILHOUETTE 13MMX32"	MDT
97799718	PARADIGM SILHOUETTE 17MMX23	MDT
97799483	PARADIGM SILHOUETTE 17MMX32"	MDT
97799719	PARADIGM SILHOUETTE 17MMX43	MDT
97799529	PARADIGM SILHOUETTE CANNULA 13MM	MDT
97799528	PARADIGM SILHOUETTE CANNULA 17MM	MDT

QUICK-SET DEVICE

97799486	QUICK-SET 6MMX18	MDT

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

QUICK-SET DEVICE

97799744	QUICK-SET 6MMX23 TUBING	MDT
97799487	QUICK-SET 6MMX32	MDT
97799743	QUICK-SET 6MMX43 TUBING	MDT
97799742	QUICK-SET 9MMX23 TUBING	MDT
97799488	QUICK-SET 9MMX32	MDT
97799741	QUICK-SET 9MMX43 TUBING	MDT

RAPID-D DEVICE

97799650	RAPID-D 10MM/110CM	ROD
97799652	RAPID-D 10MM/60CM	ROD
97799651	RAPID-D 10MM/80CM	ROD
97799656	RAPID-D 6MM/110CM	ROD
97799658	RAPID-D 6MM/60CM	ROD
97799657	RAPID-D 6MM/80CM	ROD
97799653	RAPID-D 8MM/110CM	ROD
97799655	RAPID-D 8MM/60CM	ROD
97799654	RAPID-D 8MM/80CM	ROD

SURE-T DEVICE

97799521	PARADIGM SURE-T 29G 6MMX18	MDT
97799520	PARADIGM SURE-T 29G 6MMX23	MDT
97799519	PARADIGM SURE-T 29G 8MMX23	MDT

TENDER DEVICE

97799644	TENDER-1 17MM/110CM	ROD
97799646	TENDER-1 17MM/60CM	ROD
97799645	TENDER-1 17MM/80CM	ROD
97799638	TENDER-2 17MM/110CM	ROD
97799640	TENDER-2 17MM/60CM	ROD
97799639	TENDER-2 17MM/80CM	ROD

TENDER "MINI" DEVICE

97799647	TENDER-1 MINI INF SET 13MM/110CM	ROD
97799649	TENDER-1 MINI INFSET 13MM/60CM	ROD
97799648	TENDER-1 MINI INFSET 13MM/80CM	ROD
97799641	TENDER-2 MINI INF SET 13MM/110CM	ROD
97799643	TENDER-2 MINI INFSET 13MM/60CM	ROD
97799642	TENDER-2 MINI INFSET 13MM/80CM	ROD

ULTRAFLEX DEVICE

97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799668	ULTRAFLEX 1 8MM/110CM	ROD
97799670	ULTRAFLEX 1 8MM/60CM	ROD
97799669	ULTRAFLEX 1 8MM/80CM	ROD

SYRINGE

97799707	RESERVOIR PARADIGM 5X1.8ML	MDT

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

SYRINGE

97799706	RESERVOIR PARADIGM 7X3.0ML	MDT

ISOPROPYL ALCOHOL

0.5% PAD

00809357	ALCOHOL SWABS	BTD

70% PAD

00480452	ALCOHOL PREP	PDI
00977187	ALCOHOL SWABS 6893 BUTTERFLY	BTD
00977195	ALCOHOL SWABS 6896 (150)	BTD
02247809	ALCOHOL SWABS ANTISEPTIC SKIN CLEANERS	TIP
99038349	ALCOHOL SWABS BD REGULAR	BTD
97799880	BD ALCOHOL SWABS	BTD
99438102	MONOJECT ALCOHOL WIPES	SHM
00795232	WEBCOL ALCOHOL PREP	COV

LANCET

LANCET

97799494	ACCU-CHEK FASTCLIK LANCET	ROD
97799495	ACCU-CHEK FASTCLIK LANCET	ROD
97799817	ACCU-CHEK MULTICLIX LANCET	ROD
97799946	ACCU-CHEK MULTICLIX LANCET	ROD
97799945	ACCU-CHEK SOFTCLIX LANCET	ROD
97799466	BG STAR LANCET	SAC
97799541	EZ HEALTH ORACLE LANCET	TRE
97799825	FINGERSTIX LANCET	BAY
97799292	FIRST CANADIAN HEALTH LANCETS	ARA
97799826	FREESTYLE LANCET	BAY
97799918	MICROLET LANCET	BAY
97799810	MPD THIN LANCET (NS)	MPD
97799811	MPD THIN LANCET (NS)	MPD
97799807	MPD ULTRA THIN LANCET (100)	MPD
97799808	MPD ULTRA THIN LANCET (200)	MPD
97799970	ONETOUCH ULTRASOFT LANCET	JAJ
97799348	ULTILET CLASSIC LANCET	UNK

21G LANCET

97799804	MONOLET 21G LANCET	TYC

28G LANCET

97799232	DROPLET PERSONAL LANCET 28G	SFA
97799253	FIRST CANHEALTH 28G LANCET	ARA
97799766	ITEST SAFETY 28G LANCET	AUC
97799801	MONOLET THIN (MONOJECT) 28G	TYC

30G LANCET

97799233	DROPLET PERSONAL LANCET 30G	SFA
97799254	FIRST CANHEALTH 30G LANCET	ARA
97799388	MEDI+SURE SOFT 30G TWIST	MEC
97799389	MEDI+SURE SOFT 33G TWIST	MEC
97799431	ONE TOUCH DELICA 30G LANCET	JAJ

94:01.00 DEVICES (DIABETIC)

LANCET

33G LANCET

97799690	BD ULTRAFINE 33G LANCET	BTD
97799234	DROPLET PERSONAL LANCET 33G	SFA
97799255	FIRST CANHEALTH 33G LANCET	ARA
97799767	ITEST ULTRA-THIN 33G LANCET	AUC
97799501	ONETOUCH DELICA 33G LANCET	JAJ

MAGNIFIER

DEVICE

99400550	SYRINGE SCALE MAGNIFIER	UNK

PEN NEEDLE

NEEDLE

97799433	BD AUTOSHIELD DUO SAFETY PEN NEEDLE	BDT
09991447	BD BLUNT 18GX1 1/2 FILTER	BDT
09991387	BD PRECISIONGLIDE 25GX1 NEEDLE	BTD
00909114	BD ULTRA-FINE III PEN NEEDLE	BTD
00897590	NOVOLIN-PEN NEEDLE	NOO
97799280	SURECOMFORT 29GX1/2 NEEDLE	UNK
97799269	SURECOMFORT 30GX5/16 NEEDLE	UNK
97799279	SURECOMFORT 31GX3/16 NEEDLE	UNK
97799268	SURECOMFORT 31GX5/16 NEEDLE	UNK
97799278	SURECOMFORT 32GX1/4 NEEDLE	UNK
97799267	SURECOMFORT 32GX5/32 NEEDLE	UNK

29GX10MM NEEDLE

97799238	DROPLET PEN NEEDLE 10MM 29G	SFA

29GX12.7MM NEEDLE

97799561	SUPER-FINE STANDARD 29G-12.7MM	PMS

29GX12MM NEEDLE

97799235	DROPLET PEN NEEDLE 12MM 29G	SFA
97799566	INSUPEN 29GX12MM NEEDLE	DPI
97799543	ULTICARE 29GX12MM PEN NEEDLE	UMI
97799991	UNIFINE 29G 12MM NEEDLE	AUC

29GX8MM NEEDLE

97799526	BD AUTOSHIELD PEN NEEDLES	BTD

30GX6MM NEEDLE

97799911	NOVOFINE 30GX 6MM NEEDLE	NVC

30GX8MM NEEDLE

97799567	INSUPEN 30GX8MM NEEDLE	DPI
97799910	NOVOFINE 30GX 8MM NEEDLE	NVC

31GX4.5MM NEEDLE

97799404	CLICKFINE PEN NEEDLE 31G 4.5MM	AUC

31GX5MM NEEDLE

97799282	BD ULTRAFINE 31G 5MM PEN NEEDLE	BTD
97799239	DROPLET PEN NEEDLE 5MM 31G	SFA
97799563	SUPER-FINE MICRO 31G-5MM NEEDLE	PMS
97799426	UNIFINE PENTIPS 31GX5MM	AUC

31GX6MM NEEDLE

97799405	CLICKFINE PEN NEEDLE 31G 6MM	AUC
97799237	DROPLET PEN NEEDLE 6MM 31G	SFA

94:01.00 DEVICES (DIABETIC)

PEN NEEDLE

31GX6MM NEEDLE

97799364	INSULIN PEN NEEDLE 31GX6MM	MDT
97799569	INSUPEN 31GX6MM NEEDLE	DPI
97799545	ULTICARE 31GX6MM PEN NEEDLE	UMI
97799993	UNIFINE 31G.6MM NEEDLE	AUC

31GX8MM NEEDLE

97799281	BD ULTRAFINE 31G 8MM PEN NEEDLE	BTD
97799406	CLICKFINE PEN NEEDLE 31G 8MM	AUC
97799236	DROPLET PEN NEEDLE 8MM 31G	SFA
97799366	INSULIN PEN NEEDLE 31GX8MM	MDT
97799568	INSUPEN 31GX8MM NEEDLE	DPI
97799441	LIFE BRAND PEN NEEDLE 31G 8MM	HOD
97799562	SUPER-FINE XTRA 31G-8MM NEEDLE	PMS
97799544	ULTICARE 31GX8MM PEN NEEDLE	UMI
00963976	ULTRAFINE III NEEDLE 31G 8MM	BTD
97799992	UNIFINE 31G.8MM NEEDLE	AUC

32GX4MM NEEDLE

97799527	BD ULTRA-FINE NANO PEN NEEDLE	BTD
97799243	DROPLET PEN NEEDLE 4MM 32G	SFA
97799367	INSULIN PEN NEEDLE 32GX4MM	MDT
97799399	INSUPEN 32GX4MM NEEDLE	DPI
97799334	MONTKIDDY BLUE NEEDLE 32GX4MM	MDT
97799337	MONTKIDDY GREEN NEEDLE 32GX4MM	MDT
97799335	MONTKIDDY PINK NEEDLE 32GX4MM	MDT
97799336	MONTKIDDY YELLOW NEEDLE 32GX4MM	MDT
97799386	NOVOFINE PLUS 4MM NEEDLE	NOO
97799440	ULTICARE 32GX4MM PEN NEEDLE	DPI

32GX5MM NEEDLE

97799242	DROPLET PEN NEEDLE 5MM 32G	SFA

32GX6MM NEEDLE

97799241	DROPLET PEN NEEDLE 6MM 32G	SFA
97799363	INSULIN PEN NEEDLE 32GX6MM	MDT
97799571	INSUPEN 32GX6MM NEEDLE	DPI

32GX8MM NEEDLE

97799240	DROPLET PEN NEEDLE 8MM 32G	SFA
97799365	INSULIN PEN NEEDLE 32GX8MM	MDT
97799570	INSUPEN 32GX8MM NEEDLE	DPI

33GX4MM NEEDLE

97799383	INSUPEN 33GX4MM NEEDLE	DPI

21G NEEDLE

09991504	BD BUTTERFLY NEEDLE 21G	BTD

29G NEEDLE

97799897	BD ULTRA-FINE PEN NEEDLE 29G	BTD

30G NEEDLE

97799467	NOVOTWIST TIP 30G NEEDLE	NOO

32G NEEDLE

97799821	NOVOFINE 32G TIP PEN NEEDLE	NOO
97799468	NOVOTWIST TIP 32G NEEDLE	NOO

94:01.00 DEVICES (DIABETIC)

SHARPS CONTAINER

DEVICE

99401026	BC SHARPS CONTAINER 1.4L	BTD
99401027	BD SHARPS CONTAINER 3.1L	BTD
99401033	SHARPS NESTABLE YELLOW LARGE 22.7L	UNK

SYRINGE & NEEDLE

27GX1/2 NEEDLE

09991381	BD PRECISIONGLIDE 27GX1/2	BTD

18G NEEDLE

09991402	BD PRECISIONGLIDE 18GX1 1/2	BTD
09991401	BD PRECISIONGLIDE 18GX1 NEEDLE	BTD

25G NEEDLE

09991385	BD PRECISIONGLIDE 25GX5/8	BTD
09991386	BD PRECISIONGLIDE 25GX7/8	BTD

26G NEEDLE

09991384	BD PRECISIONGLIDE 26GX1/2	BTD
09991383	BD PRECISIONGLIDE 26GX3/8	BTD

27G NEEDLE

09991382	BD PRECISIONGLIDE 27GX1 1/4	BTD

SYRINGE

00977020	PLASTIPAK MICRO	BTD
97799510	ULTICARE LOW DEAD SPACE SYRINGE	UMI

0.25CC SYRINGE

99002132	INSULIN SYR W/NEEDL 0.25CC	UNK

0.3CC SYRINGE

00977961	BD MICRO-FINE 0.3CC SYRINGE	BTD
99002140	INSULIN SYR W/NEEDLE 0.3CC	UNK

0.5CC SYRINGE

00920096	E-Z JE	RIV
99002159	INSULIN SYR W/NEEDLE 0.5CC	UNK
00977136	MONOJECT	BTD

0.5CC/1CC SYRINGE

00977128	MONOJECT	MDT

1CC SYRINGE

00920061	E-Z JE	RIV
99002167	INSULIN SYR W/NEEDLE 1CC	UNK

1ML SYRINGE

09991376	BD LUER-LOK TIP 1ML SYRINGE	BTD
09991375	BD SLIP TIP 1ML SYRINGE	BTD

3ML SYRINGE

09991371	BD LUER-LOK TIP 3ML SYRINGE	BTD
09991372	BD SLIP TIP 3ML SYRINGE	BTD

5ML SYRINGE

09991373	BD LUER-LOK TIP 5ML SYRINGE	BTD
09991374	BD SLIP TIP 5ML SYRINGE	BTD

8MM SYRINGE

97799261	SURECOMFORT 5/16 IN 30GX0.3CC	UNK
97799272	SURECOMFORT 5/16 IN 30GX0.5CC	UNK
97799265	SURECOMFORT 5/16 IN 30GX1CC	UNK
97799273	SURECOMFORT 5/16 IN 31GX0.3CC	UNK
97799274	SURECOMFORT 5/16 IN 31GX0.3CC	UNK
97799263	SURECOMFORT 5/16 IN 31GX0.5CC	UNK
97799262	SURECOMFORT 5/16 IN 31GX1CC	UNK

94:01.00 DEVICES (DIABETIC)

SYRINGE & NEEDLE

10ML SYRINGE

09991363	BD LUER-LOK TIP 10ML SYRINGE	BTD
09991364	BD SLIP TIP 10ML SYRINGE	BTD

12MM SYRINGE

97799275	SURECOMFORT 1/2 IN 28GX1CC SYRINGE	UNK

12.7MM SYRINGE

97799257	SURECOMFORT 1/2 IN 28GX0.5CC	UNK
97799260	SURECOMFORT 1/2 IN 29GX0.3CC	UNK
97799259	SURECOMFORT 1/2 IN 29GX0.5CC	UNK
97799258	SURECOMFORT 1/2 IN 29GX1CC	UNK
97799264	SURECOMFORT 1/2 IN 30GX0.3CC	UNK
97799270	SURECOMFORT 1/2 IN 30GX0.5CC	UNK
97799271	SURECOMFORT 1/2 IN 30GX1CC	UNK

18GX1 1/2 SYRINGE

09991349	BD LUER-LOK TIP 18GX1 1/2 SYRINGE	BTD

20ML SYRINGE

09991368	BD LUER-LOK TIP 20ML SYRINGE	BTD
09991369	BD SLIP TIP 20ML SYRINGE	BTD

21GX1 SYRINGE

09991360	BD TUBERCULIN 21GX1 SYRINGE	BTD

22GX1 1/2 SYRINGE

09991341	BD LUER-LOK TIP 22GX1 1/2 SYRINGE	BTD

23GX5/8 SYRINGE

09991339	BD LUER-LOK TIP 25GX5/8 SYRINGE	BTD

25GX1 SYRINGE

09991338	BD LUER-LOK TIP 25GX1 SYRINGE	BTD

25GX1 1/2 SYRINGE

09991337	BD LUER-LOK TIP 25GX1 1/2 SYRINGE	BTD

25GX5/8 SYRINGE

09991359	BD TUBERCULIN 25GX5/8 SYRINGE	BTD

26GX3/8 SYRINGE

09991358	BD TUBERCULIN 26GX3/8 SYRINGE	BTD

26GX5/8 SYRINGE

09991361	BD SLIP TIP SUB Q 26G SYRINGE	BTD

27GX1/2 SYRINGE

09991356	BD TUBERCULIN 27GX1/2 SYRINGE	BTD
09991357	BD TUBERCULIN 27GX1/2 SYRINGE	BTD

28GX0.5CC SYRINGE

00920177	BD MICRO-FINE 28GX0.5CC SYRINGE	BTD
97799518	ULTICARE 1/2 IN 28GX0.5CC SYRINGE	UMI

28GX1CC SYRINGE

00920185	BD MICRO-FINE 28GX1CC SYRINGE	BTD
97799517	ULTICARE 1/2 IN 28GX1CC SYRINGE	UMI

94:01.00 DEVICES (DIABETIC)

SYRINGE & NEEDLE

29GX0.3CC SYRINGE

97799509	ULTI SYG 1/2 IN 29GX0.3CC	UMI
97799999	ULTICARE 29GX0.3CC	AUC
97799887	ULTRA 29G3/10CC	BTD

29GX0.5CC SYRINGE

97799888	BD ULTRA 29G.1/2CC SYRINGE	BTD
97799508	ULTI SYG 1/2 IN 29GX0.5CC	UMI
97799998	ULTICARE 29GX0.5CC	AUC

29GX1CC SYRINGE

97799889	BD ULTRA 29G.1CC SYRINGE	BTD
97799507	ULTI SYG 1/2 IN 29GX1CC SYRINGE	UMI
97799997	ULTICARE 29GX0.1CC	AUC

30GX0.3CC SYRINGE

97799551	ULTI SYG 1/2 IN 30GX0.3CC	UMI
97799506	ULTI SYG 5/16 IN 30GX0.3CC	UMI
97799996	ULTICARE 30GX0.3CC	AUC
97799886	ULTRA-FINE II 30GX0.3 CC SYRINGE	BTD

30GX0.5CC SYRINGE

97799885	BD ULTRA-FINE II 30GX0.5CC SYRINGE	BTD
97799550	ULTI SYG 1/2 IN 30GX0.5CC	UMI
97799505	ULTI SYG 5/16 IN 30GX0.5CC	UMI
97799995	ULTICARE 30GX0.5CC	AUC

30GX1CC SYRINGE

97799549	ULTI SYG 1/2 IN 30GX1CC SYRINGE	UMI
97799504	ULTI SYG 5/16 IN 30GX1CC SYRINGE	UMI
97799994	ULTICARE 30GX0.1CC	AUC
97799890	ULTRA-FINE II 30G.1CC	BTD

30ML SYRINGE

09991377	BD LUER-LOK TIP 30ML SYRINGE	BTD
09991378	BD SLIP TIP 30ML SYRINGE	BTD

31GX0.3CC SYRINGE

97799369	INSULIN 31GX0.3CC	MDT
97799548	ULTI SYG 5/16 IN 31GX0.3CC	UMI
97799513	ULTICARE 5/16 IN 31GX0.3CC SYRINGE	UMI

31GX0.5CC SYRINGE

97799370	INSULIN 31GX0.5CC	MDT
97799547	ULTI SYG 5/16 IN 31GX0.5CC	UMI
97799512	ULTICARE 5/16 IN 31GX0.5CC SYRINGE	UMI

31GX1CC SYRINGE

97799371	INSULIN 31GX1CC	MDT
97799546	ULTI SYG 5/16 IN 31GX1CC SYRINGE	UMI
97799511	ULTICARE 5/16 IN 31GX1CC SYRINGE	UMI

31GX6MMX0.3CC SYRINGE

97799425	BD SYRINGE WITH ULTRA-FINE NEEDLE	BTD

31X6MMX0.5CC SYRINGE

97799385	BD SYRINGE + NEEDLE	BTD

94:01.00 DEVICES (DIABETIC)

SYRINGE & NEEDLE

31X6MMX1CC SYRINGE

97799384	BD SYRINGE + NEEDLE	BTD

60ML SYRINGE

09991455	BD LUER-LOK TIP 60ML SYRINGE	BTD
09991454	BD SLIP TIP 60ML SYRINGE	BTD

SYRINGE CASE

DEVICE

99400552	MYHEALTH SYRINGE CASE-7	AUC
99400551	MYHEALTH SYRINGE CASE-SINGLE	AUC

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

ITRACONAZOLE

POWDER

09991094	ITRACONAZOLE PDR	MDS

NUTRITIONAL SUPPLEMENT

POWDER

09991319	SOURCE THICKEN UP 227G	NVC

THICKENING AGENT

POWDER

12137029	RESOURCE THICKEN CLEAR	NVC

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

POWDER

99100176	VANCOMYCIN	MDS

WATER

SOLUTION

00905178	STERILE WATER	UNK
99002264	STERILE WATER	UNK

APPENDIX A
LIMITED USE BENEFITS AND CRITERIA

08:00 ANTI-INFECTIVE AGENTS

08:12.02 AMINOGLYCOSIDES

AMIKACIN SULFATE

Limited use benefit (prior approval required).

250MG LIQUID

02242971	AMIKACIN SULFATE	SDZ

TOBRAMYCIN

Limited use benefit (prior approval required).

1.2G POWDER FOR SOLUTION

00533688	TOBRAMYCIN	FKD
02285150	TOBRAMYCIN	RAX

10MG/ML SOLUTION

02230639	TOBRAMYCIN	FKD
02241209	TOBRAMYCIN	SDZ

40MG/ML SOLUTION

02420287	JAMP-TOBRAMYCIN	JMP
02230640	TOBRAMYCIN	FKD
02241210	TOBRAMYCIN	SDZ
02382814	TOBRAMYCIN	MYL
99005069	TOBRAMYCINE	UNK

08:12.06 CEPHALOSPORINS

CEFTAZIDIME

Limited use benefit (prior approval required).

1G POWDER FOR SOLUTION

00886971	CEFTAZIDIME	FKD
02437848	CEFTAZIDIME	RAX
02212218	FORTAZ 1G	GSK

2G POWDER FOR SOLUTION

00886955	CEFTAZIDIME	FKD
02437856	CEFTAZIDIME	RAX
02212226	FORTAZ 2G	GSK

3G POWDER FOR SOLUTION

02439522	CEFTAZIDIME	RAX

6G POWDER FOR SOLUTION

00886963	CEFTAZIDIME	FKD
02437864	CEFTAZIDIME	RAX
02212234	FORTAZ 6G	GSK

08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS

ERTAPENEM

Limited use benefit (prior approval required).

1G POWDER FOR SOLUTION

02247437	INVANZ	FRS

MEROPENEM

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

02378787	MEROPENEM	SDZ
02218488	MERREM	AZC

1G POWDER FOR SOLUTION

02378795	MEROPENEM	SDZ

08:12.07 MISCELLANEOUS B-LACTAM ANTIBIOTICS

MEROPENEM

Limited use benefit (prior approval required).

1G POWDER FOR SOLUTION

02436507	MEROPENEM	RAX
02218496	MERREM	AZC

08:12.16 PENICILLINS

PIPERACILLIN, TAZOBACTAM

Limited use benefit (prior approval required).

2G & 0.25G POWDER FOR SOLUTION

02299623	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02370158	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

3G & 0.375G POWDER FOR SOLUTION

02299631	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308452	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362627	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370166	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

4G & 0.5G POWDER FOR SOLUTION

02299658	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02308460	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	APX
02362635	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX
02370174	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	TEV

12G & 1.5G POWDER FOR SOLUTION

02330547	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	SDZ
02377748	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX

36G & 4.5G POWDER FOR SOLUTION

02439131	PIPERACILLIN SODIUM/TAZOBACTAM SODIUM	RAX

08:12.18 QUINOLONES

LEVOFLOXACIN HEMIHYDRATE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

250MG TABLET

02315424	ACT LEVOFLOXACIN	TEV
02284707	APO-LEVOFLOXACIN	APX
02284677	PMS-LEVOFLOXACIN	PMS
02298635	SANDOZ LEVOFLOXACIN	SDZ
02248262	TEVA-LEVOFLOXACIN	TEV

500MG TABLET

02315432	ACT LEVOFLOXACIN	TEV
02284715	APO-LEVOFLOXACIN	APX
02415879	LEVOFLOXACIN	PDL
02284685	PMS-LEVOFLOXACIN	PMS
02298643	SANDOZ LEVOFLOXACIN	SDZ
02248263	TEVA-LEVOFLOXACIN	TEV

750MG TABLET

02315440	ACT LEVOFLOXACIN	TEV
02325942	APO-LEVOFLOXACIN	APX
02305585	PMS-LEVOFLOXACIN	PMS
02298651	SANDOZ LEVOFLOXACIN	SDZ
02285649	TEVA-LEVOFLOXACIN	TEV

08:12.18 QUINOLONES

MOXIFLOXACIN HYDROCHLORIDE

Limited use benefit (prior approval not required).

Coverage will be limited to 14 tablets every 14 days, followed by a 14 day lockout.

400MG TABLET

02404923	APO-MOXIFLOXACIN	APX
02432242	AURO-MOXIFLOXACIN	AUR
02242965	AVELOX	BAY
02443929	JAMP-MOXIFLOXACIN	JMP
02447061	JAMP-MOXIFLOXACIN	JMP
02447053	MAR-MOXIFLOXACIN	MAR
02457814	MED-MOXIFLOXACIN	GMP
02462974	MOXIFLOXACIN	PDL
02450976	RIVA-MOXIFLOXACIN	RIV
02383381	SANDOZ MOXIFLOXACIN	SDZ
02375702	TEVA-MOXIFLOXACIN	TEV

08:12.24 TETRACYCLINES

MINOCYCLINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For patients who cannot tolerate other tetracyclines or doxycycline.
For patients with severe widespread acne who have failed on tetracycline or doxycycline.

50MG CAPSULE

02084090	APO-MINOCYCLINE	APX
02239667	DOM-MINOCYCLINE	DPC
02153394	MINOCYCLINE	PDL
02287226	MINOCYCLINE	SAN
02230735	MYLAN-MINOCYCLINE	MYL
02294419	PMS-MINOCYCLINE	PMS
02237313	SANDOZ MINOCYCLINE	SDZ
02108143	TEVA-MINOCYCLINE	TEV

100MG CAPSULE

02084104	APO-MINOCYCLINE	APX
02239668	DOM-MINOCYCLINE	DPC
02154366	MINOCYCLINE	PDL
02239982	MINOCYCLINE	IVX
02287234	MINOCYCLINE	SAN
02230736	MYLAN-MINOCYCLINE	MYL
02294427	PMS-MINOCYCLINE	PMS
02237314	SANDOZ MINOCYCLINE	SDZ
02108151	TEVA-MINOCYCLINE	TEV

08:12.28 MISCELLANEOUS ANTIBIOTICS

LINEZOLID

Limited use benefit (prior approval required).

Tablets:
For treatment of proven vancomycin-resistant enterococci (VRE) infections.
For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

I.V. Solution:
When linezolid cannot be administered orally in the above mentioned situations;

2MG/ML SOLUTION

02402637	LINEZOLID	TEV
02243685	ZYVOXAM	PFI

08:12.28 MISCELLANEOUS ANTIBIOTICS

LINEZOLID

Limited use benefit (prior approval required).

Tablets:
For treatment of proven vancomycin-resistant enterococci (VRE) infections.
For the treatment of proven methicillin-resistant staphylococcus aureus (MRSA) infections in patients who cannot tolerate vancomycin.

I.V. Solution:
When linezolid cannot be administered orally in the above mentioned situations;

600MG TABLET

02426552	APO-LINEZOLID	APX
02422689	SANDOZ LINEZOLID	SDZ
02243684	ZYVOXAM	PFI

RIFAXIMIN

Limited use benefit (prior approval required).

For reducing the risk of overt hepatic encephalopathy (HE) recurrence in patients:
- Who are unable to achieve adequate control of HE recurrence with a maximal tolerated dose of lactulose alone; AND
- When used in combination with a maximal tolerated dose of lactulose.

550MG TABLET

02410702	ZAXINE	SLX

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

500MG POWDER FOR SOLUTION

02420295	JAMP-VANCOMYCIN	JMP
02406535	MYLAN-VANCOMYCIN	MYL
02342855	VAL-VANCOMYCIN	VAE
02139375	VANCOMYCIN	FKD
02230191	VANCOMYCIN	PFI
02394626	VANCOMYCIN	SDZ
02407914	VANCOMYCIN	MYL
02411032	VANCOMYCIN	RAX
02435713	VANCOMYCIN	GMP

1,000MG POWDER FOR SOLUTION

02230192	VANCOMYCIN	PFI
02396386	VANCOMYCIN	RAX
02435721	VANCOMYCIN	GMP

1G POWDER FOR SOLUTION

02420309	JAMP-VANCOMYCIN	JMP
02406543	MYLAN-VANCOMYCIN	MYL
02241821	PMS-VANCOMYCIN 1 G	PMS
02342863	VAL-VANCOMYCIN	VAE
02139383	VANCOMYCIN	FKD
02394634	VANCOMYCIN	SDZ
02407922	VANCOMYCIN	MYL

5G POWDER FOR SOLUTION

02420317	JAMP-VANCOMYCIN	JMP
02406551	MYLAN-VANCOMYCIN	MYL
02139243	VANCOMYCIN	FKD
02378337	VANCOMYCIN	PFI
02394642	VANCOMYCIN	SDZ
02407930	VANCOMYCIN	MYL

10G POWDER FOR SOLUTION

02420325	JAMP-VANCOMYCIN	JMP
02406578	MYLAN-VANCOMYCIN	MYL

08:12.28 MISCELLANEOUS ANTIBIOTICS

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

10G POWDER FOR SOLUTION

02405830	VAL-VANCOMYCIN	VAE
02241807	VANCOMYCIN	FKD
02378345	VANCOMYCIN	PFI
02394650	VANCOMYCIN	SDZ
02407949	VANCOMYCIN	MYL
02411040	VANCOMYCIN	RAX

08:14.08 AZOLES

VORICONAZOLE

Limited use benefit (prior approval required).

For the treatment of patients with invasive aspergillosis; OR
For the treatment of culture proven invasive candidiasis with documented resistance to fluconazole.

50MG TABLET

02409674	APO-VORICONAZOLE	APX
02399245	SANDOZ VORICONAZOLE	SDZ
02396866	TEVA-VORICONAZOLE	TEV
02256460	VFEND	PFI

200MG TABLET

02409682	APO-VORICONAZOLE	APX
02399253	SANDOZ VORICONAZOLE	SDZ
02396874	TEVA-VORICONAZOLE	TEV
02256479	VFEND	PFI

08:18.08 ANTIRETROVIRALS

TENOFOVIR DISOPROXIL FUMARATE

Limited use benefit (prior approval required).

For the treatment of patients with HIV-1 infection who have failed or have experienced adverse events to an alternative agent.
For the treatment of patients with chronic hepatitis B infection who have cirrhosis documented on radiologic or histologic grounds and a HBV concentration above 2,000 IU/mL.

245MG TABLET

02247128	VIREAD	GIL

08:18.20 INTERFERONS

PEGINTERFERON ALFA-2A

Limited use benefit (prior approval required).

For the treatment of patients with chronic hepatitis B infection who have a HBV DNA concentration above 2,000 IU/mL without decompensated cirrhosis, upon the written request of a hepatologist or other specialist in this area.

180MCG/0.5ML SOLUTION

02248077	PEGASYS	HLR

PEGINTERFERON ALFA-2A, RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.
- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

180MCG/0.5ML & 200MG KIT

02253429	PEGASYS RBV	HLR

180MCG/1ML & 200MG KIT

02253410	PEGASYS RBV	HLR

08:18.20 INTERFERONS

PEGINTERFERON ALFA-2B, RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C in patients who are treatment naïve, upon the written request of a hepatologist or other specialist in this area.
- For genotypes 1, 4, 5 and 6, an initial 24 week supply will be approved. A further 24 week supply may be approved if patient has a viral reduction of at least 2 logs or HCV is undetectable at 12 weeks (48 weeks total).
- For genotypes 2 or 3, initial coverage for a maximum of 24 weeks will be approved. Renewals will not be covered.

50MCG/0.5ML & 200MG KIT

02254573	PEGETRON KIT	FRS

08:18.32 NUCLEOSIDES AND NUCLEOTIDES

ADEFOVIR DIPIVOXIL

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection when used in combination with lamivudine in patients who have developed failure to lamivudine, as defined by an increase in HBV DNA of ≥ 1 log10 IU/mL above the nadir, measured on two separate occasions within an interval of at least one month, after the first three months of lamivudine therapy, and when failure to lamivudine is not due to poor adherence to therapy.

10MG TABLET

02420333	APO-ADEFOVIR	APX
02247823	HEPSERA	GIL

ENTECAVIR MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis B infection in patients with cirrhosis documented on radiologic or histologic grounds and a HBV DNA concentration above 2000IU/mL.

0.5MG TABLET

02396955	APO-ENTECAVIR	APX
02448777	AURO-ENTECAVIR	AUR
02282224	BARACLUDE	BMS
02430576	PMS-ENTECAVIR	PMS

08:18.40 HCV ANTIVIRALS

DACLATASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

30MG TABLET

02444747	DAKLINZA	BMS

60MG TABLET

02444755	DAKLINZA	BMS

ELBASVIR, GRAZOPREVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

50MG & 100MG TABLET

02451131	ZEPATIER	FRS

08:18.40 HCV ANTIVIRALS

OMBITASVIR, PARITAPREVIR, RITONAVIR, DASABUVIR

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C virus (HCV) Genotype 1 infection in adults with a liver fibrosis stage ≥ F2 (Metavir score or equivalent);
AND
Patient is unable to take the following chronic hepatitis C medications based on intolerance/contraindication:
- Epclusa (sofosbuvir-velpatasvir)
- Harvoni (ledipasvir-sofosbuvir)
- Zepatier (elbasvir-grazoprevir)
- Daklinza (daclatasvir) + Sunvepra (asunaprevir)

Criteria & Duration
Treatment naïve and experienced Genotype 1b, non-cirrhotic* - 12 weeks.
Treatment naïve and experienced Genotype 1a, non-cirrhotic - 12 weeks in combination with RBV.
Treatment naïve and experienced Genotype1b, cirrhotic - 12 weeks in combination with RBV.
Treatment naïve and experienced (prior relapses and prior partial responders) Genotype 1a, cirrhotic - 12 weeks in combination with RBV.
Treatment experienced Genotype 1a, with cirrhosis, and who have had a previous null response to pegIFN and RBV - 24 weeks in combination with RBV.

*Holkira Pak with ribavirin is recommended in patients with an unknown Genotype 1 subtype or with mixed Genotype 1 infection.

250MG & 12.5MG & 75MG & 50MG TABLET

02436027 HOLKIRA PAK	ABV

RIBAVIRIN

Limited use benefit (prior approval required).

For the treatment of chronic hepatitis C.

200MG TABLET

02439212 IBAVYR	PED

400MG TABLET

02425890 IBAVYR	PED

600MG TABLET

02425904 IBAVYR	PED

SIMEPREVIR SODIUM

Limited use benefit (prior approval required).

For the treatment of chronic Hepatitis C in treatment-naïve and treatment-experienced patients who meet all of the following criteria:
- Chronic hepatitis C virus (HCV) genotype 1 infection; AND
- Detectable levels of HCV RNA in the last six months; AND
- Fibrosis stage F2 or greater (Metavir scale or equivalent); AND
- Patient has not received a prior full therapeutic course of boceprevir or telaprevir.

Not eligible for coverage:
- Patients currently being treated with another HCV antiviral agent.
- Patients who have previously received a treatment course of Galexos (Re-treatment requests will not be considered).

150MG CAPSULE

02416441 GALEXOS	JSO

SOFOSBUVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG TABLET

02418355 SOVALDI	GIL

08:18.40 HCV ANTIVIRALS

SOFOSBUVIR, LEDIPASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG & 90MG TABLET

02432226	HARVONI	GIL

SOFOSBUVIR, VELPATASVIR

Limited use benefit (prior approval required).

For adult patients with chronic hepatitis C infection at any fibrosis stage (F0-F4) who meet ALL of the following criteria:
Treatment is prescribed by a hepatologist, gastroenterologist, or infectious disease specialist (or other prescriber experienced in treating patients with chronic hepatitis C); AND
Laboratory confirmed hepatitis C genotype 1, 2, 3, 4, 5, 6 or mixed genotype; AND
Laboratory confirmed quantitative HCV RNA level taken in the last 12 months;

Retreatment for failure or re-infection in patients who have received an adequate prior course of direct-acting antivirals will be considered on a case-by-case basis.

400MG & 100MG TABLET

02456370	EPCLUSA	GIL

08:36.00 URINARY ANTI-INFECTIVES

FOSFOMYCIN TROMETHAMINE

Limited use benefit (prior approval required).

For the treatment of women (>12 years old) with:
- Urinary tract infections with organisms resistant to first line therapy; OR
- Urinary tract infections in pregnancy when first-line agents are contraindicated.

3G/PK POWDER

02240335	MONUROL	PAL

10:00 ANTINEOPLASTIC AGENTS

10:00.00 ANTINEOPLASTIC AGENTS

ABIRATERONE ACETATE

Limited use benefit (prior approval required).

Initial coverage criteria (Initial approval for 12 months)
For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who are asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) and who have not received prior chemotherapy if they meet the following criteria:
- Used in combination with prednisone; AND
- Patient has an ECOG performance status of 0 or 1.

For the treatment of metastatic castration resistant prostate cancer patients (mCRPC) who progressed on docetaxel-based chemotherapy if they meet the following criteria:
- Used in combination with prednisone; AND
- Patient has an ECOG performance status ≤ 2; AND
- Abiraterone is not used as an add-on therapy to enzalutamide (Xtandi); AND
- Abiraterone has not been used in the pre-docetaxel setting.

Renewal coverage criteria (Renewal for 12 months)
There is no objective evidence of disease progression

250MG TABLET

02371065	ZYTIGA	JSO

500MG TABLET

02457113	ZYTIGA	JSO

10:00.00 ANTINEOPLASTIC AGENTS

AFATINIB DIMALEATE

Limited use benefit (prior approval required).

For the treatment of patients with advanced Non-Small Cell Lung Cancer (NSCLC) who meet ALL of the following criteria:
- First line treatment of patients; AND
- EGFR mutation positive; AND
- Advanced or metastatic adenocarcinoma of the lung; AND
- An ECOG performance status of 0 or 1.

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

Use of afatinib precludes the use of any other EGFR inhibitor as a subsequent line of therapy.

20MG TABLET

02415666	GIOTRIF	BOE

30MG TABLET

02415674	GIOTRIF	BOE

40MG TABLET

02415682	GIOTRIF	BOE

COBIMETINIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for cobimetinib (Cotellic):
For the first-line treatment of patients with metastatic or unresectable melanoma in combination with vemurafenib (Zelboraf).

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

20MG TABLET

02452340	COTELLIC	HLR

DABRAFENIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for dabrafenib (Tafinlar):
- For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
- For the first-line treatment of patients with metastatic or unresectable melanoma in combination with trametinib (Mekinist)

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG* performance status of 0 to 1;

*ECOG = European Cooperative Oncology Group Status

AND
- Patient is previously untreated.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

50MG CAPSULE

02409607	TAFINLAR	NVR

75MG CAPSULE

02409615	TAFINLAR	NVR

10:00.00 ANTINEOPLASTIC AGENTS

ENZALUTAMIDE

Limited use benefit (prior approval required).

For the treatment of patients with metastatic castration-resistant prostate cancer (mCRPC) who are/have:
- Asymptomatic or mildly symptomatic after failure of androgen deprivation therapy (ADT) who have not received prior chemotherapy; AND
- Have an ECOG performance status of 0 or 1 with no risk factors for seizures; OR
- Progressed on docetaxel-based chemotherapy with an ECOG performance status ≤2 and no risk factors for seizures; AND
- Would be an alternative to abiraterone for patients in the post-docetaxel setting but would not be an add-on therapy to abiraterone treatment.

Patients previously treated with abiraterone would not be eligible for enzalutamide unless unable to tolerate abiraterone.

Use of enzalutamide in the post-docetaxel setting is not permitted if previously used in the pre-chemotherapy setting.

40MG CAPSULE

02407329	XTANDI	AST

ERLOTINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Treatment of non-small cell lung cancer (NSCLC) after failure of at least one prior chemotherapy regimen, and whose EGFR expression status is positive or unknown.

25MG TABLET

02461862	APO-ERLOTINIB	APX
02269007	TARCEVA	HLR
02377691	TEVA-ERLOTINIB	TEV

100MG TABLET

02461870	APO-ERLOTINIB	APX
02454386	PMS-ERLOTINIB	PMS
02269015	TARCEVA	HLR
02377705	TEVA-ERLOTINIB	TEV

150MG TABLET

02461889	APO-ERLOTINIB	APX
02454394	PMS-ERLOTINIB	PMS
02269023	TARCEVA	HLR
02377713	TEVA-ERLOTINIB	TEV

IDELALISIB

Limited use benefit (prior approval required).

Criteria for initial six month coverage:
- For the treatment of patients with relapsed chronic lymphocytic leukemia (CLL) in combination with rituximab. Treatment should continue until unacceptable toxicity or disease progression.

Criteria for assessment every six months:
- There is no objective evidence of disease progression.

100MG TABLET

02438798	ZYDELIG	GIL

150MG TABLET

02438801	ZYDELIG	GIL

IMATINIB MESYLATE

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

100MG TABLET

02355337	APO-IMATINIB	APX
02253275	GLEEVEC	NVR
02397285	NAT-IMATINIB	NPH
02431114	PMS-IMATINIB	PMS
02399806	TEVA-IMATINIB	TEV

10:00.00 ANTINEOPLASTIC AGENTS

IMATINIB MESYLATE

Limited use benefit (prior approval required).

- For the treatment of patients with chronic myeloid leukemia (CML) in blast crisis, accelerated phase, or in chronic phase.
- For the treatment of patients with gastrointestinal stromal tumour.
- For newly diagnosed adult patients with Philadelphia chromosome-positive (CML).

400MG TABLET

02355345	APO-IMATINIB	APX
02253283	GLEEVEC	NVR
02397293	NAT-IMATINIB	NPH
02431122	PMS-IMATINIB	PMS
02399814	TEVA-IMATINIB	TEV

LENALIDOMIDE

Limited use benefit (prior approval not required).

For the treatment of Myelodysplastic syndrome (MDS)
Initial coverage criteria (Initial approval for 6 months):
- Demonstrated diagnosis of Myelodysplastic syndrome (MDS) on bone marrow aspiration; AND
- Documented presence of del(5q) abnormality by standard cytogenetic or fluorescence in situ hybridization; AND
- International prognostic scoring system (IPSS) risk category low or intermediate-1; AND
- Transfusion-dependent symptomatic anemia.

Renewal coverage criteria (Renewal for 12 months):
- Patient has demonstrated a reduction in transfusion requirements of at least 50%.

For the treatment of Refractory/relapsed Multiple Myeloma after one prior therapy (MM-AOPT)
Initial coverage criteria (Initial approval for 12 months):
- Progressive Multiple Myeloma; AND
- For use in combination with dexamethasone; AND
- Patient is refractory to initial or subsequent treatments or has relapsed after the conclusion of prior treatments and is suitable for further chemotherapy; OR
- Patient has completed at least one full treatment regimen as initial therapy and has demonstrated an intolerance to their current chemotherapy.

Renewal coverage criteria (Renewal for 12 months):
- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

For the treatment of Newly diagnosed Multiple Myeloma for patients who are not eligible for autologous stem cell transplant - (MM-TNE)
Initial coverage criteria (Initial approval for 12 months):
- As a first-line treatment option for newly diagnosed patients with multiple myeloma who are not candidates for autologous stem-cell transplant; AND
- For use in combination with dexamethasone; AND
- Who have an ECOG performance status of 0 to 2.

Renewal coverage criteria (Renewal for 12 months):
- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

For the maintenance treatment for newly diagnosed Multiple Myeloma post-autologous stem cell transplant
Initial coverage criteria (Initial approval for 12 months):
- Newly diagnosed Multiple Myeloma; AND
- The disease is stable or improved, with no evidence of progression after autologous stem-cell transplant.

Coverage is provided for lenalidomide at an initial dose of 10 mg daily. Doses adjustments of up to 15 mg daily may be required based on individual patient characteristics/response.

Renewal coverage criteria (Renewal for 12 months):
- There is no objective evidence of disease progression or development of unacceptable toxicity to lenalidomide requiring discontinuation of therapy.

5MG CAPSULE

02304899	REVLIMID	UNK

10MG CAPSULE

02304902	REVLIMID	UNK

15MG CAPSULE

02317699	REVLIMID	UNK

20MG CAPSULE

02440601	REVLIMID	UNK

25MG CAPSULE

02317710	REVLIMID	UNK

10:00.00 ANTINEOPLASTIC AGENTS

LENVATINIB

Limited use benefit (prior approval required).

Initial coverage criteria (initial approval for 4 months):
- Used as monotherapy for treatment of patients with locally recurrent or metastatic, progressive differentiated thyroid cancer (DTC); AND
- DTC is refractory to radioactive iodine treatment; AND
- Have an ECOG* performance status of ≤ 2;

AND

Patient meets the eligibility criteria of the SELECT trial as follows:
- Pathologically confirmed differentiated thyroid cancer (patients with anaplastic or medullary thyroid cancer are not eligible)
- Evidence of iodine-131 refractory disease according to at least one of the following criteria:
- At least one measurable lesion without iodine uptake on any iodine-131 scan
- At least one measurable lesion that had progressed according to RECIST criteria within 12 months after iodine-131 therapy despite iodine-131 avidity at the time of treatment
- Total lifetime radioactive iodine dose greater than 600 mCi (millicurie)
- Radiologic evidence of progression within the previous 13 months
- No prior therapy with a tyrosine kinase inhibitor or have received one prior treatment regimen with a tyrosine kinase inhibitor

Renewal coverage criteria (4 months):
There is no objective evidence of disease progression.

10MG CAPSULE

02450321	LENVIMA	EIS

14MG CAPSULE

02450313	LENVIMA	EIS

20MG CAPSULE

02450305	LENVIMA	EIS

24MG CAPSULE

02450291	LENVIMA	EIS

PAZOPANIB

Limited use benefit (prior approval required).

Initial coverage criteria (12 months)
For the first-line treatment of patients with advanced or metastatic clear cell renal carcinoma; AND
Patient has an ECOG performance status of 0 to 2.

Renewal coverage criteria (12 months)
There is no objective evidence of disease progression.

200MG TABLET

02352303	VOTRIENT	NVR

PONATINIB HYDROCHLORIDE

Limited use benefit (prior approval required).

Criteria for initial six (6) month coverage:
- For the treatment of patients who have confirmed T315i mutation positive disease, independent of previous TKI therapy; OR
- Treatment of last resort for patients with intolerances or contraindications to imatinib and all other second generation TKI's (dasatinib, nilotinib, bosutinib); OR
- For the treatment of patients with chronic phase chronic myeloid leukemia (CML) who have resistance/disease progression after at least two prior lines of TKI therapy where Iclusig would be available as third-line TKI option; OR
- For the treatment of patients with accelerated phase or blast phase CML or Ph+ ALL who have resistance or disease progression after at least one second generation TKI therapy; AND
- An ECOG performance status of 0 to 2.

Note: Second generation TKI's (dasatinib, nilotinib, bosutinib) are not covered as options after ponatinib.

Criteria for assessment every six (6) month:
- There is no objective evidence of disease progression.

15MG TABLET

02437333	ICLUSIG	ARI

45MG TABLET

02437341	ICLUSIG	ARI

10:00.00 ANTINEOPLASTIC AGENTS

RITUXIMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Initial coverage is provided for 24 weeks at a dose of 1000 mg x 2 doses at 0 & 2 weeks.
- Prescribed by a rheumatologist

For the treatment of adult patients with severely active rheumatoid arthritis who have failed to respond to a trial of an anti-TNF agent. Treatment should be combined with methotrexate. Rituximab should not be used in combination with anti-TNF agents.

For continued coverage for rituximab beyond twenty-four weeks, patient must meet all the following criteria:
- Initially prescribed by a rheumatologist;

AND
Patient has been assessed after the twentieth to twenty-fourth week of rituximab therapy and meets the response criteria of:
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of GRANULOMATOSIS POLYANGIITIS OR MICROSCOPIC POLYANGIITIS

Coverage is provided at a dose of 375 mg/m2body surface area, administered as an IV infusion once weekly for 4 weeks.

For the induction of remission in patients with severely active granulomatosis with polyangiitis or microscopic polyangiitis; AND
- Who have failed an adequate trial of cyclophosphamide; OR
- Who have a contraindication to cyclophosphamide.

10MG/ML SOLUTION

02241927	RITUXAN	HLR

SUNITINIB MALATE

Limited use benefit (Prior approval required).

Criteria for initial six month coverage of Sutent:
- For patients with histologically proven unresectable or recurrent/metastatic GIST who have failed or are unable to tolerate imatinib therapy.

Sunitinib will not be funded concomitantly with imatinib.

Criteria for assessment at every 12 months:
- There is no objective evidence of disease progression.

12.5MG CAPSULE

02280795	SUTENT	PFI

25MG CAPSULE

02280809	SUTENT	PFI

50MG CAPSULE

02280817	SUTENT	PFI

TEMOZOLOMIDE

Limited use benefit (prior approval required).

For treatment of adult patients with glioblastoma multiform or anaplastic astrocytoma, and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy).
For treatment of adult patients with newly diagnosed glioblastoma multiform concomitantly with radiotherapy and then as maintenance treatment.

5MG CAPSULE

02441160	ACT TEMOZOLOMIDE	ACG
02443473	TARO-TEMOZOLOMIDE	TAR
02241093	TEMODAL	FRS

20MG CAPSULE

02395274	ACT TEMOZOLOMIDE	ACG
02443481	TARO-TEMOZOLOMIDE	TAR
02241094	TEMODAL	FRS

100MG CAPSULE

02395282	ACT TEMOZOLOMIDE	ACG
02443511	TARO-TEMOZOLOMIDE	TAR
02241095	TEMODAL	FRS

10:00.00 ANTINEOPLASTIC AGENTS

TEMOZOLOMIDE

Limited use benefit (prior approval required).

For treatment of adult patients with glioblastoma multiform or anaplastic astrocytoma, and documented evidence of recurrence or progression after standard therapy (resection, radiotherapy, and chemotherapy).
For treatment of adult patients with newly diagnosed glioblastoma multiform concomitantly with radiotherapy and then as maintenance treatment.

140MG CAPSULE

02395290	ACT TEMOZOLOMIDE	ACG
02413116	APO-TEMOZOLOMIDE	APX
02443538	TARO-TEMOZOLOMIDE	TAR
02312794	TEMODAL	FRS

250MG CAPSULE

02395312	ACT TEMOZOLOMIDE	ACG
02443554	TARO-TEMOZOLOMIDE	TAR
02241096	TEMODAL	FRS

TRAMETINIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for trametinib (Mekinist):
- For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
- For the first-line treatment of patients with metastatic or unresectable melanoma in combination with dabrafenib(Tafinlar)

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG* performance status of 0 to 1;

*ECOG = European Cooperative Oncology Group Status

AND
- Patient is previously untreated.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

0.5MG TABLET

02409623	MEKINIST	NVR

2MG TABLET

02409658	MEKINIST	NVR

VEMURAFENIB

Limited use benefit (prior approval required).

Criteria for the initial six-month coverage for vemurafenib (Zelboraf):
For the first-line treatment of patients with metastatic or unresectable melanoma as monotherapy; OR
For the first-line treatment of patients with metastatic or unresectable melanoma in combination with cobimetinib (Cotellic)

AND for patients who meet the following criteria:
- Patient has documented BRAF V600 mutation-positive unresectable or metastatic melanoma; AND
- Patient does not have brain metastases or brain metastases are asymptomatic or stable; AND
- Patient has an ECOG performance status of 0 to 1.

Renewal coverage criteria (6 months):
There is no objective evidence of disease progression.

240MG TABLET

02380242	ZELBORAF	HLR

12:00 AUTONOMIC DRUGS

12:04.00 PARASYMPATHOMIMETIC AGENTS

DONEPEZIL HYDROCHLORIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

5MG TABLET

02419866	ACCEL-DONEPEZIL	ACP
02397595	ACT DONEPEZIL	ACG
02362260	APO-DONEPEZIL	APX
02232043	ARICEPT	PFI
02400561	AURO-DONEPEZIL	AUR
02412853	BIO-DONEPEZIL	BMI
02402645	DONEPEZIL	ACC
02416417	DONEPEZIL	PDL
02420597	DONEPEZIL	SIV
02425343	ECL-DONEPEZIL	ECL
02404419	JAMP-DONEPEZIL	JMP
02416948	JAMP-DONEPEZIL	JMP
02402092	MAR-DONEPEZIL	MAR
02359472	MYLAN-DONEPEZIL	MYL
02439557	NAT-DONEPEZIL	NPH
02322331	PMS-DONEPEZIL	PMS
02381508	RAN-DONEPEZIL	RBY
02412918	RIVA-DONEPEZIL	RIV
02328666	SANDOZ DONEPEZIL	SDZ
02428482	SEPTA DONEPEZIL	SPT
02340607	TEVA-DONEPEZIL	TEV

10MG TABLET

02419874	ACCEL-DONEPEZIL	ACP
02397609	ACT DONEPEZIL	ACG
02362279	APO-DONEPEZIL	APX
02232044	ARICEPT	PFI
02400588	AURO-DONEPEZIL	AUR
02412861	BIO-DONEPEZIL	BMI
02402653	DONEPEZIL	ACC
02416425	DONEPEZIL	PDL
02420600	DONEPEZIL	SIV
02425351	ECL-DONEPEZIL	ECL
02404427	JAMP-DONEPEZIL	JMP
02416956	JAMP-DONEPEZIL	JMP
02402106	MAR-DONEPEZIL	MAR
02359480	MYLAN-DONEPEZIL	MYL
02439565	NAT-DONEPEZIL	NPH
02322358	PMS-DONEPEZIL	PMS
02381516	RAN-DONEPEZIL	RBY
02412934	RIVA-DONEPEZIL	RIV
02328682	SANDOZ DONEPEZIL	SDZ

12:04.00 PARASYMPATHOMIMETIC AGENTS

DONEPEZIL HYDROCHLORIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

10MG TABLET

02428490	SEPTA DONEPEZIL	SPT
02340615	TEVA-DONEPEZIL	TEV

GALANTAMINE HYDROBROMIDE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

8MG CAPSULE (EXTENDED RELEASE)

02425157	AURO-GALANTAMINE ER	AUR
02443015	GALANTAMINE	SAN
02416573	GALANTAMINE ER	PDL
02420821	MAR-GALANTAMINE ER	MAR
02339439	MYLAN-GALANTAMINE ER	MYL
02316943	PAT-GALANTAMINE ER	KLA
02398370	PMS-GALANTAMINE ER	PMS
02377950	TEVA-GALANTAMINE ER	TEV

16MG CAPSULE (EXTENDED RELEASE)

02425165	AURO-GALANTAMINE ER	AUR
02443023	GALANTAMINE	SAN
02416581	GALANTAMINE ER	PDL
02420848	MAR-GALANTAMINE ER	MAR
02339447	MYLAN-GALANTAMINE ER	MYL
02316951	PAT-GALANTAMINE ER	KLA
02398389	PMS-GALANTAMINE ER	PMS
02377969	TEVA-GALANTAMINE ER	TEV

24MG CAPSULE (EXTENDED RELEASE)

02425173	AURO-GALANTAMINE ER	AUR
02443031	GALANTAMINE	SAN
02416603	GALANTAMINE ER	PDL
02420856	MAR-GALANTAMINE ER	MAR
02339455	MYLAN-GALANTAMINE ER	MYL
02316978	PAT-GALANTAMINE ER	KLA
02398397	PMS-GALANTAMINE ER	PMS
02377977	TEVA-GALANTAMINE ER	TEV

12:04.00 PARASYMPATHOMIMETIC AGENTS

RIVASTIGMINE HYDROGEN TARTRATE

Limited use benefit (prior approval required).

Initial 12 month coverage for cholinesterase inhibitors:
- Diagnosis of mild to moderate Alzheimer's disease; AND
- Mini Mental State Exam (MMSE) score of 10-26, established within the last 60 days; OR
- Montreal Cognitive Assessment (MoCA) score of 10-26, established within the last 60 days; OR
- Global Deterioration Scale (GDS) score between 4 to 6, established within the last 60 days.

Continued coverage beyond 12 months will be based on improvement or stabilization of cognition, function or behaviour.

Criteria for coverage at every 12 month interval:
- Clinically meaningful response as determined by stabilization or improvement while on therapy; AND
- Alzheimer's Disease has not progressed to GDS stage 7 or MMSE or MoCA less than 10.

1.5MG CAPSULE

02336715	APO-RIVASTIGMINE	APX
02242115	EXELON	NVR
02401614	MED-RIVASTIGMINE	GMP
02305984	NOVO-RIVASTIGMINE	NOP
02306034	PMS-RIVASTIGMINE	PMS
02311283	RATIO-RIVASTIGMINE	TEV
02416999	RIVASTIGMINE	PDL
02324563	SANDOZ RIVASTIGMINE	SDZ

3MG CAPSULE

02336723	APO-RIVASTIGMINE	APX
02242116	EXELON	NVR
02401622	MED-RIVASTIGMINE	GMP
02305992	NOVO-RIVASTIGMINE	NOP
02306042	PMS-RIVASTIGMINE	PMS
02311291	RATIO-RIVASTIGMINE	TEV
02417006	RIVASTIGMINE	PDL
02324571	SANDOZ RIVASTIGMINE	SDZ

4.5MG CAPSULE

02336731	APO-RIVASTIGMINE	APX
02242117	EXELON	NVR
02401630	MED-RIVASTIGMINE	GMP
02306018	NOVO-RIVASTIGMINE	NOP
02306050	PMS-RIVASTIGMINE	PMS
02311305	RATIO-RIVASTIGMINE	TEV
02417014	RIVASTIGMINE	PDL
02324598	SANDOZ RIVASTIGMINE	SDZ

6MG CAPSULE

02336758	APO-RIVASTIGMINE	APX
02242118	EXELON	NVR
02401649	MED-RIVASTIGMINE	GMP
02306026	NOVO-RIVASTIGMINE	NOP
02306069	PMS-RIVASTIGMINE	PMS
02311313	RATIO-RIVASTIGMINE	TEV
02417022	RIVASTIGMINE	PDL
02324601	SANDOZ RIVASTIGMINE	SDZ

2MG/ML SOLUTION

02245240	EXELON	NVR

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

ACLIDINIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

400MCG POWDER

02409720	TUDORZA GENUAIR	AZC

GLYCOPYRRONIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

50MCG CAPSULE

02394936	SEEBRI BREEZHALER	NVR

INDACATEROL MALEATE, GLYCOPYRRONIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

110MCG & 50MCG CAPSULE

02418282	ULTIBRO BREEZHALER	NVR

TIOTROPIUM BROMIDE MONOHYDRATE

Limited use benefit (prior approval required).

For patients with chronic obstructive pulmonary disease (COPD) and who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

18MCG CAPSULE

02246793	SPIRIVA	BOE

2.5MCG SOLUTION

02435381	SPIRIVA RESPIMAT	BOE

TRIMEBUTINE MALEATE

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR
In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

100MG TABLET

02349027	AA-TRIMEBUTINE	AAP
02245663	TRIMEBUTINE	AAP

200MG TABLET

02349035	AA-TRIMEBUTINE	AAP
00803499	MODULON	APC
02245664	TRIMEBUTINE	AAP

UMECLIDINIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- did not respond to a trial of ipratropium; OR
- did not have a previous trial of ipratropium, but who have moderate to severe COPD, as defined by spirometry.

62.5MCG POWDER

02423596	INCRUSE ELLIPTA	GSK

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

62.5MCG/25MCG POWDER

02418401	ANORO ELLIPTA	GSK

12:12.08 BETA ADRENERGIC AGONISTS

ACLIDINIUM BROMIDE, FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- Moderate to severe COPD, as defined by spirometry; AND
- Inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

400MCG & 12MCG POWDER

02439530	DUAKLIR GENUAIR	AZC

FLUTICASONE FUROATE, VILANTEROL TRIFENATATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

100MCG & 25MCG POWDER

02408872	BREO ELLIPTA	GSK

FLUTICASONE FUROATE, VILANTEROL TRIFENATATE (ASTHMA)

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.

200MCG & 25MCG POWDER

02444186	BREO ELLIPTA	GSK

FORMOTEROL FUMARATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.
OR
For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

12MCG/CAPSULE CAPSULE

02230898	FORADIL	NVR

FORMOTEROL FUMARATE DIHYDRATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

6MCG/DOSE POWDER

02237225	OXEZE TURBUHALER	AZC

12MCG/DOSE POWDER

02237224	OXEZE TURBUHALER	AZC

12:12.08 BETA ADRENERGIC AGONISTS

FORMOTEROL FUMARATE DIHYDRATE, BUDESONIDE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

6MCG & 100MCG/INHALATION POWDER

02245385	SYMBICORT 100 TURBUHALER	AZC

6MCG & 200MCG/INHALATION POWDER

02245386	SYMBICORT 200 TURBUHALER	AZC

FORMOTEROL FUMARATE DIHYDRATE, MOMETASONE FUROATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of rapid onset, short duration bronchodilator.

5MCG & 100MCG/INHALATION AEROSOL

02361752	ZENHALE	FRS

5MCG & 200MCG/INHALATION AEROSOL

02361760	ZENHALE	FRS

5MCG & 50MCG/INHALATION AEROSOL

02361744	ZENHALE	FRS

INDACATEROL MALEATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who:
- are not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist; OR
- have moderate to severe COPD, as defined by spirometry.

75MCG CAPSULE

02376938	ONBREZ BREEZHALER	NVR

OLODATEROL HYDROCHLORIDE, TIOTROPIUM BROMIDE MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; AND
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

2.5MCG & 2.5MCG SOLUTION

02441888	INSPIOLTO RESPIMAT	BOE

SALMETEROL XINAFOATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are using optimal corticosteroid therapy and experiencing breakthrough symptoms requiring regular use of a rapid-onset, short-duration bronchodilator.
OR
For the treatment of Chronic Obstructive Pulmonary Disease (COPD) in patients not adequately controlled with either ipratropium, tiotropium or a short acting beta-agonist.

50MCG/INHALATION POWDER

02214261	SEREVENT DISKHALER	GSK
02231129	SEREVENT DISKUS	GSK

12:12.08 BETA ADRENERGIC AGONISTS

SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE

Limited use benefit (prior approval required).

For the treatment of asthma in patients who are not adequately controlled on medium doses of inhaled corticosteroids (e.g. fluticasone 251-500mcg daily, or the equivalent) as the sole agent and require addition of a long-acting beta agonist. Patients using this combination product must also have access to a short-acting bronchodilator for symptomatic relief.
OR
For the treatment of chronic obstructive pulmonary disease (COPD) in patients who have:
- moderate to severe COPD, as defined by spirometry; OR
- inadequate response to a long-acting beta-2 agonist (LABA) or a long-acting muscarinic antagonist (LAMA).

25MCG & 125MCG AEROSOL

02245126	ADVAIR 125	GSK

25MCG & 250MCG AEROSOL

02245127	ADVAIR 250	GSK

50MCG & 100MCG POWDER

02240835	ADVAIR 100 DISKUS	GSK

50MCG & 250MCG POWDER

02240836	ADVAIR 250 DISKUS	GSK

50MCG & 500MCG POWDER

02240837	ADVAIR 500 DISKUS	GSK

12:20.04 CENTRALL ACTING SKELETAL MUSCLE RELAXANTS

CYCLOBENZAPRINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For relief of muscle spasm associated with acute, painful musculoskeletal conditions. Coverage is limited to 60mg per day for three (3) weeks renewable every two (2) months.

10MG TABLET

02177145	APO-CYCLOBENZAPRINE	APX
02348853	AURO-CYCLOBENZAPRINE	AUR
02220644	CYCLOBENZAPRINE	PDL
02287064	CYCLOBENZAPRINE	SAN
02424584	CYCLOBENZAPRINE	SIV
02238633	DOM-CYCLOBENZAPRINE	DPC
02357127	JAMP-CYCLOBENZAPRINE	JMP
02231353	MYLAN-CYCLOBENZAPRINE	MYL
02212048	PMS-CYCLOBENZAPRINE	PMS
02242079	RIVA-CYCLOBENZAPRINE	RIV
02080052	TEVA-CYCLOBENZAPRINE	TEV

TIZANIDINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of spasticity in patients with multiple sclerosis, who have failed therapy with or are intolerant to baclofen.

4MG TABLET

02239170	PAL-TIZANIDINE	PAL
02259893	TIZANIDINE	AAP

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (GUM)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

2MG GUM

02091933	NICORETTE GUM	KIM
80015240	RUGBY NICOTINE POLACRILEX GUM	ACG

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (GUM)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

2MG GUM

80000396	THRIVE NICOTINELL GUM	GSK

4MG GUM

02091941	NICORETTE GUM	KIM
80000118	NICOTINE GUM	PER
80000402	THRIVE NICOTINELL GUM	NVC

NICOTINE (INHALER)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 doses during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

10MG SPRAY

02241742	NICORETTE INHALER	KIM

NICOTINE (LOZENGE)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage is limited to 945 pieces during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for nicotine gum or lozenges when one year has elapsed from the day the initial prescription was filled.

1MG LOZENGE

80007461	THRIVE NICOTINE LOZENGES	NVC

2MG LOZENGE

02247347	NICORETTE LOZENGE	KIM
80007464	THRIVE NICOTINE LOZENGES	NVC

4MG LOZENGE

02247348	NICORETTE LOZENGE	KIM

NICOTINE (PATCH)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage will be provided for up to the allowable number of patches for one of the following products, during a one-year period. The year starts on the date the first prescription is filled.
The number of patches covered in the one-year period is:
- Habitrol 168 patches; OR
- Nicoderm 140 patches; OR
- Nicotrol 140 patches

Once this quantity has been reached, the client is eligible again for coverage for nicotine patches when one year has elapsed from the day the initial prescription was filled.

5MG PATCH

02028697	NICOTROL TRANSDERMAL	UNK

7MG PATCH

01943057	HABITROL	NVC
80044393	TRANSDERMAL NICOTINE	ACG

10MG PATCH

02029405	NICOTROL TRANSDERMAL	UNK

14MG PATCH

01943065	HABITROL	NVC
80013549	NICOTINE TRANSDERMAL SYSTEM	ADD
80044392	TRANSDERMAL NICOTINE	ACG

12:92.00 MISCELLANEOUS AUTONOMIC DRUGS

NICOTINE (PATCH)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:
Coverage will be provided for up to the allowable number of patches for one of the following products, during a one-year period. The year starts on the date the first prescription is filled.
The number of patches covered in the one-year period is:
- Habitrol 168 patches; OR
- Nicoderm 140 patches; OR
- Nicotrol 140 patches

Once this quantity has been reached, the client is eligible again for coverage for nicotine patches when one year has elapsed from the day the initial prescription was filled.

15MG PATCH

02029413	NICOTROL TRANSDERMAL	UNK

18MG PATCH

02241227	TRANSDERMAL NICOTINE PATCHDAY	NVC

21MG PATCH

01943073	HABITROL	NVC
02241228	NICOTINE TRANSDERMAL	NVC
80014250	NICOTINE TRANSDERMAL SYSTEM	ADD
80044389	TRANSDERMAL NICOTINE	ACG

35MG PATCH

02241226	TRANSDERMAL NICOTINE PATCHDAY	NVC

36MG PATCH

02093111	NICODERM	KIM

78MG PATCH

02093138	NICODERM	KIM

114MG PATCH

02093146	NICODERM	KIM

VARENICLINE TARTRATE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage will be limited to 165 tablets during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached, the client is eligible again for coverage for varenicline (Champix®) when one year has elapsed from the day the initial prescription was filled.

0.5MG TABLET

02291177	CHAMPIX	PFI

0.5MG & 1MG TABLET

02298309	CHAMPIX STARTER PACK	PFI

1MG TABLET

02291185	CHAMPIX	PFI

20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS

20:04.04 IRON PREPARATIONS

POLYSACCHARIDE IRON COMPLEX

Limited use benefit (prior approval not required).

For children 12 years of age or under.

15MG POWDER

80033717	FERAMAX POWDER WATER SOLUBLE POLYSACCHARIDE IRON COMPLEX	BSY

20:12.04 ANTICOAGULANTS

APIXABAN

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require apixaban for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

OR

For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE)

2.5MG TABLET

02377233	ELIQUIS	BMS

5MG TABLET

02397714	ELIQUIS	BMS

DABIGATRAN ETEXILATE MESILATE

Limited use benefit (prior approval required).

For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require dabigatran etexilate for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation with warfarin is not possible due to inability to regularly monitor via INR testing (i.e., no access to INR testing services at a laboratory, clinic, pharmacy and at home).

110MG CAPSULE

02312441	PRADAXA	BOE

150MG CAPSULE

02358808	PRADAXA	BOE

RIVAROXABAN

Limited use benefit (prior approval required).

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto) for Stroke Prevention in Atrial Fibrillation (SPAF)
For at-risk patients (CHADS2 score ≥1) with non-valvular atrial fibrillation who require rivaroxaban for the prevention of stroke and systemic embolism AND in whom:
- Anticoagulation is inadequate (outside the desired INR range for at least 35% of the tests) with a two-month trial of warfarin; OR
- Anticoagulation with warfarin is contraindicated; OR
- Anticoagulation is not possible due to inability to regularly monitor via International Normalized Ratio (INR) testing (i.e., no access to INR testing service at a laboratory, clinic, pharmacy, and at home)

Criteria for rivaroxaban 15 mg, 20mg tablets (Xarelto)
For the treatment of venous thromboembolism: Deep Vein Thrombosis (DVT) or Pulmonary Embolism (PE).

10MG TABLET

02316986	XARELTO	BAY

15MG TABLET

02378604	XARELTO	BAY

20MG TABLET

02378612	XARELTO	BAY

20:16.00 HEMATOPOIETIC AGENTS

PEGFILGRASTIM

Limited use benefit (prior approval required).

CHEMOTHERAPY SUPPORT

Primary Prophylaxis
For use in previously untreated patients receiving a moderate to severely myelosuppressive chemotherapy regimen (i.e. ≥40% incidence of febrile neutropenia). Febrile neutropenia is defined as a temperature ≥38.5°C or >38.0°C three times in a 24 hour period and neutropenia with an absolute neutrophil count (ANC) <0.5 x 109/L.

Secondary Prophylaxis
For use in patients receiving myelosuppressive chemotherapy who have experienced an episode of febrile neutropenic sepsis or profound neutropenia in a previous cycle of chemotherapy; OR
For use in patients who have experienced a dose reduction or treatment delay longer than one week, due to neutropenia.

The recommended dosage of pegfilgrastim is a single subcutaneous injection of 6 mg, administered once per cycle of chemotherapy. Pegfilgrastim should be administered no sooner than 24 hours after the administration of cytotoxic chemotherapy.

10MG/ML SOLUTION

02249790	NEULASTA	AMG

PLERIXAFOR

Limited use benefit (prior approval not required).

For use in combination with filgrastim to mobilize hematopoietic stem cells for subsequent autologous transplantation in patients with:
- Non-Hodgkin's lymphoma (NHL); OR
- Multiple myeloma (MM);

AND
- Prescribed by an oncologist or hematologist.

AND if one of the following are met
- A PBCD34+ count of < 10 cells/uL after 4 days of filgrastim; OR
- Less than 50% of the target CD34 yield is achieved on the 1st day of apheresis (after being mobilized with filgrastim alone or following chemotherapy); OR
- If a patient has failed a previous stem cell mobilization with filgrastim alone or following chemotherapy.

Reimbursement is limited to a maximum of 4 doses (0.24mg/kg given daily) for a single mobilization attempt.
The dose of Mozobil is limited to a maximum of 40mg per day

20MG SOLUTION

02377225	MOZOBIL	SAC

24:00 CARDIOVASCULAR DRUGS

24:12.12 PHOSPHODIESTERASE INHIBITORS

SILDENAFIL CITRATE

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization.

20MG TABLET

02418118	APO-SILDENAFIL R	APX
02412179	PMS-SILDENAFIL R	PMS
02279401	REVATIO	PFI
02319500	TEVA-SILDENAFIL R	TEV

TADALAFIL

Limited use benefit (prior approval required).

Must be initiated by a Pulmonary Hypertension specialist

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization.

20MG TABLET

02338327	ADCIRCA	LIL
02421933	APO-TADALAFIL PAH	APX

24:12.92 MISCELLANEOUS VASODILATING AGENTS

AMBRISENTAN

Limited use benefit (prior approval required).

Maximum dose covered is 10 mg once daily.

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND
- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

5MG TABLET

02307065	VOLIBRIS	GSK

10MG TABLET

02307073	VOLIBRIS	GSK

BOSENTAN MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice daily

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND
- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

62.5MG TABLET

02386194	ACT BOSENTAN	ACG
02399202	APO-BOSENTAN	APX
02383497	MYLAN-BOSENTAN	MYL
02383012	PMS-BOSENTAN	PMS
02386275	SANDOZ BOSENTAN	SDZ
02398400	TEVA-BOSENTAN	TEV
02244981	TRACLEER	ACN

125MG TABLET

02386208	ACT BOSENTAN	ACG
02383500	MYLAN-BOSENTAN	MYL
02383020	PMS-BOSENTAN	PMS
02386283	SANDOZ BOSENTAN	SDZ
02244982	TRACLEER	ACN

24:32.20 MINERALOCORTICOIDE (ALDOSTERONE) RECEPTOR ANTAGONISTS

EPLERENONE

Limited use benefit (prior approval required).

For the treatment of patients with New York Heart Association (NYHA) class II chronic heart failure with left ventricular systolic dysfunction (with ejection fraction ≤ 35%), as an adjunct to standard therapy.

Note: Patients must be on optimal therapy with an angiotensin-converting-enzyme (ACE) inhibitor or an angiotensin-receptor blocker (ARB), and a beta-blocker (unless contraindicated) at the recommended dose or maximal tolerated dose.

25MG TABLET

02323052	INSPRA	PFI

50MG TABLET

02323060	INSPRA	PFI

24:32.92

VALSARTAN, SACUBITRIL

Limited use benefit (prior approval required).

For the treatment of New York Heart Association (NYHA) class II or III heart failure if the following criteria are met:
- Must be initiated by a physician experienced in the treatment of heart failure; AND
- Left ventricular ejection fraction < 40%; AND
- NYHA class II to III symptoms despite at least four weeks of treatment with an angiotensin-converting enzyme inhibitor (ACEI) or an angiotensin II receptor antagonist (ARB); OR If your patient has a contraindication or intolerance to ACEI or ARBs;

AND
- Must be used in combination with a beta blocker and an aldosterone antagonist (if tolerated); OR If your patient has a contraindication or intolerance to beta blockers or aldosterone antagonists.

26MG & 24MG TABLET

02446928	ENTRESTO	NVR

51MG & 49MG TABLET

02446936	ENTRESTO	NVR

103MG & 97MG TABLET

02446944	ENTRESTO	NVR

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:08.04 NONSTEROIDAL ANTI-INFLAMMATORY AGENTS

ACETYLSALICYLIC ACID

Limited use benefit (prior approval is not required).

ASA 80 mg tablets are a benefit to clients age 21 years and under to allow access for use in pediatric conditions (e.g. Kawasaki Syndrome).

80MG TABLET

02269139	ACETYLSALICYLIC ACID	JMP
02295563	LOWPRIN	EUR
02202360	RIVASA	RIV

80MG TABLET (CHEWABLE)

02009013	ASAPHEN	PMS
02280167	ASATAB	ODN
02250675	EURO-ASA	EUR
02296004	LOWPRIN	SDZ
02429950	M-ASA	MAN
02311518	PRO-AAS	PDL
02202352	RIVASA	RIV

80MG TABLET (DELAYED RELEASE)

02427176	ASA EC	SAN
02238545	ASAPHEN	PMS
02283905	JAMP-ASA	JMP
02311496	PRO-AAS	PDL

DICLOFENAC SODIUM (TOPICAL)

Limited use benefit (prior approval required).

For the treatment of osteoarthritis when:
- pain is inadequately controlled with acetaminophen AND a non-steroidal anti-inflammatory (NSAID); OR
- there is contraindication to acetaminophen and NSAID; OR
- there is intolerance to acetaminophen and NSAID.

1.5% SOLUTION

02354403	APO-DICLOFENAC	APX
02434571	DICLOFENAC TOPICAL	RAX
02356783	PMS-DICLOFENAC	PMS
02420988	TARO-DICLOFENAC	TAR

28:08.08 OPIATE AGONISTS

ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

300MG & 15MG & 15MG TABLET

00653241	RATIO-LENOLTEC NO 2	TEV
02163934	TYLENOL WITH CODEINE NO.2	JSO

300MG & 15MG & 30MG TABLET

00653276	RATIO-LENOLTEC NO 3	TEV
02163926	TYLENOL WITH CODEINE NO.3	JSO

325MG & 30MG & 15MG TABLET

00293504	ATASOL 15	CHU

325MG & 30MG & 30MG TABLET

00293512	ATASOL 30	CHU

ACETAMINOPHEN, CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

32MG & 1.6MG/ML ELIXIR

00816027	PMS-ACETAMINOPHEN	PMS

300MG & 30MG TABLET

01999648	ACET CODEINE 30	PMS
02232658	PROCET-30	PDL
00608882	TEVA-EMTEC-30	TEV
00789828	TRIATEC-30	RIV

ACETAMINOPHEN, OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

325MG & 5MG TABLET

02324628	APO-OXYCODONE/ACET	APX
02361361	OXYCODONE/ACET	SAN
02327171	OXYCODONE-ACET	PDL
02242468	RIVACOCET	RIV
02307898	SANDOZ OXYCODONE/ACETAMINOPHEN	SDZ
00608165	TEVA-OXYCOCET	TEV

ACETYLSALICYLIC ACID, OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

325MG & 5MG TABLET

00608157	TEVA-OXYCODAN	TEV

28:08.08 OPIATE AGONISTS

CODEINE MONOHYDRATE, CODEINE SULFATE TRIHYDRATE

Limited use benefit (prior approval required).

For treatment of:
- chronic pain and palliative care patients as an alternative to products containing codeine in combination with acetaminophen or ASA with or without caffeine; OR
- chronic pain and palliative care patients as an alternative to regular release codeine tablets when large doses are required.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

50MG TABLET (EXTENDED RELEASE)

02230302	CODEINE CONTIN CR	PFR

100MG TABLET (EXTENDED RELEASE)

02163748	CODEINE CONTIN CR	PFR

150MG TABLET (EXTENDED RELEASE)

02163780	CODEINE CONTIN CR	PFR

200MG TABLET (EXTENDED RELEASE)

02163799	CODEINE CONTIN CR	PFR

CODEINE PHOSPHATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

5MG/ML LIQUID

00050024	CODEINE PHOSPHATE	ATL

2MG/ML SOLUTION

00380571	LINCTUS CODEINE	ATL

15MG TABLET

02009889	CODEINE	RIV
00593435	TEVA-CODEINE	TEV

30MG TABLET

02009757	CODEINE	RIV
02243979	PMS-CODEINE	PMS
00593451	TEVA-CODEINE	TEV

FENTANYL

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

12MCG/HR PATCH

02386844	CO FENTANYL	OBT
02395657	FENTANYL	PDL
02396696	MYLAN-FENTANYL MATRIX	MYL
02341379	PMS-FENTANYL MTX	PMS
02330105	RAN-FENTANYL MATRIX	RBY
02327112	SANDOZ FENTANYL	SDZ
02311925	TEVA-FENTANYL	TEV

25MCG/HR PATCH

02314630	APO-FENTANYL MATRIX	APX
02386852	CO FENTANYL	OBT
02275813	DURAGESIC	JSO
02395665	FENTANYL	PDL

28:08.08 OPIATE AGONISTS

FENTANYL

Limited use benefit (prior approval required).

For the management of chronic pain in patients who are unresponsive or intolerant to at least one long-acting oral sustained released product, such as morphine, hydromorphone and oxycodone, despite appropriate dose titration and adjunctive therapy including laxatives and antiemetics.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

25MCG/HR PATCH

02396718	MYLAN-FENTANYL MATRIX	MYL
02341387	PMS-FENTANYL MTX	PMS
02330113	RAN-FENTANYL MATRIX	RBY
02327120	SANDOZ FENTANYL	SDZ
02282941	TEVA-FENTANYL	TEV

50MCG/HR PATCH

02314649	APO-FENTANYL MATRIX	APX
02386879	CO FENTANYL	OBT
02275821	DURAGESIC	JSO
02395673	FENTANYL	PDL
02396726	MYLAN-FENTANYL MATRIX	MYL
02341395	PMS-FENTANYL MTX	PMS
02330121	RAN-FENTANYL MATRIX	RBY
02327147	SANDOZ FENTANYL	SDZ
02282968	TEVA-FENTANYL	TEV

75MCG/HR PATCH

02314657	APO-FENTANYL MATRIX	APX
02386887	CO FENTANYL	OBT
02275848	DURAGESIC	JSO
02395681	FENTANYL	PDL
02396734	MYLAN-FENTANYL MATRIX	MYL
02341409	PMS-FENTANYL MTX	PMS
02330148	RAN-FENTANYL MATRIX	RBY
02327155	SANDOZ FENTANYL	SDZ
02282976	TEVA-FENTANYL	TEV

100MCG/HR PATCH

02314665	APO-FENTANYL MATRIX	APX
02386895	CO FENTANYL	OBT
02275856	DURAGESIC	JSO
02395703	FENTANYL	PDL
02396742	MYLAN-FENTANYL MATRIX	MYL
02341417	PMS-FENTANYL MTX	PMS
02330156	RAN-FENTANYL MATRIX	RBY
02327163	SANDOZ FENTANYL	SDZ
02282984	TEVA-FENTANYL	TEV

HYDROMORPHONE HYDROCHLORIDE

Limited use benefit.
Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

3MG CAPSULE (SUSTAINED RELEASE)

02125323	HYDROMORPH CONTIN	PFR

28:08.08 OPIATE AGONISTS

HYDROMORPHONE HYDROCHLORIDE

Limited use benefit.
Prior approval required for controlled release capsules only. Regular release dosage forms are full benefits and do not require prior approval.

For treatment of moderate to severe chronic pain when other opioids such as morphine have been ineffective in controlling pain or in patients experiencing intolerable side effects.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

4.5MG CAPSULE (SUSTAINED RELEASE)		
02359502	HYDROMORPH CONTIN	PFR
6MG CAPSULE (SUSTAINED RELEASE)		
02125331	HYDROMORPH CONTIN	PFR
9MG CAPSULE (SUSTAINED RELEASE)		
02359510	HYDROMORPH CONTIN	PFR
12MG CAPSULE (SUSTAINED RELEASE)		
02125366	HYDROMORPH CONTIN	PFR
18MG CAPSULE (SUSTAINED RELEASE)		
02243562	HYDROMORPH CONTIN	PFR
24MG CAPSULE (SUSTAINED RELEASE)		
02125382	HYDROMORPH CONTIN	PFR
30MG CAPSULE (SUSTAINED RELEASE)		
02125390	HYDROMORPH CONTIN	PFR
1MG/ML LIQUID		
00786535	DILAUDID	PFR
01916386	PMS HYDROMORPHONE	PMS
3MG SUPPOSITORY		
01916394	PMS HYDROMORPHONE	PMS
1MG TABLET		
02364115	APO-HYDROMORPHONE	APX
00705438	DILAUDID	PFR
00885444	PMS-HYDROMORPHONE	PMS
02319403	TEVA-HYDROMORPHONE	TEV
2MG TABLET		
02364123	APO-HYDROMORPHONE	APX
00125083	DILAUDID	PFR
00885436	PMS-HYDROMORPHONE	PMS
02319411	TEVA-HYDROMORPHONE	TEV
4MG TABLET		
02364131	APO-HYDROMORPHONE	APX
00125121	DILAUDID	PFR
00885401	PMS-HYDROMORPHONE	PMS
02319438	TEVA-HYDROMORPHONE	TEV
8MG TABLET		
02364158	APO-HYDROMORPHONE	APX
00786543	DILAUDID	PFR
00885428	PMS-HYDROMORPHONE	PMS
02319446	TEVA-HYDROMORPHONE	TEV

28:08.08 OPIATE AGONISTS

METHADONE HYDROCHLORIDE (METADOL)

Limited use benefit (prior approval required) with the following criteria:

Prescriber is registered with Health Canada and is eligible to prescribe methadone for the management of pain; AND
For the management of moderate to severe cancer pain or chronic non-cancer pain, as an alternative to other opioids; OR
For the management of pain for palliative care patients. Pharmacists may only dispense a maximum supply of 30 days at one time.

1MG/ML SOLUTION		
02247694	METADOL	PAL
10MG/ML SOLUTION		
02241377	METADOL	PAL
1MG TABLET		
02247698	METADOL	PAL
5MG TABLET		
02247699	METADOL	PAL
10MG TABLET		
02247700	METADOL	PAL
25MG TABLET		
02247701	METADOL	PAL

MORPHINE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

1MG/ML SYRUP		
00614491	DOLORAL 1	ATL
00607762	RATIO-MORPHINE	TEV
5MG/ML SYRUP		
00614505	DOLORAL 5	ATL
00607770	RATIO-MORPHINE	TEV
10MG/ML SYRUP		
00690783	RATIO-MORPHINE	TEV
20MG/ML SYRUP		
00690791	RATIO-MORPHINE	TEV

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPSULE (EXTENDED RELEASE)		
02019930	M-ESLON	ETH
15MG CAPSULE (EXTENDED RELEASE)		
02177749	M-ESLON	ETH
30MG CAPSULE (EXTENDED RELEASE)		
02019949	M-ESLON	ETH
60MG CAPSULE (EXTENDED RELEASE)		
02019957	M-ESLON	ETH
100MG CAPSULE (EXTENDED RELEASE)		
02019965	M-ESLON	ETH
200MG CAPSULE (EXTENDED RELEASE)		
02177757	M-ESLON	ETH

28:08.08 OPIATE AGONISTS

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

20MG/ML DROP

00621935	STATEX	PAL

50MG/ML DROP

00705799	STATEX	PAL

5MG SUPPOSITORY

00632228	STATEX	PAL

10MG SUPPOSITORY

00632201	STATEX	PAL

20MG SUPPOSITORY

00596965	STATEX	PAL

1MG/ML SYRUP

00591467	STATEX	PAL

5MG/ML SYRUP

00591475	STATEX	PAL

10MG/ML SYRUP

00647217	STATEX	PAL

5MG TABLET

00594652	STATEX	PAL

10MG TABLET

00594644	STATEX	PAL

25MG TABLET

00594636	STATEX	PAL

50MG TABLET

00675962	STATEX	PAL

15MG TABLET (EXTENDED RELEASE)

02350815	MORPHINE SR	SAN
02015439	MS CONTIN SR	PFR
02244790	SANDOZ MORPHINE SR	SDZ
02302764	TEVA-MORPHINE SR	TEV

30MG TABLET (EXTENDED RELEASE)

02350890	MORPHINE SR	SAN
02014297	MS CONTIN SR	PFR
02244791	SANDOZ MORPHINE SR	SDZ
02302772	TEVA-MORPHINE SR	TEV

60MG TABLET (EXTENDED RELEASE)

02350912	MORPHINE SR	SAN
02014300	MS CONTIN SR	PFR
02244792	SANDOZ MORPHINE SR	SDZ
02302780	TEVA-MORPHINE SR	TEV

100MG TABLET (EXTENDED RELEASE)

02014319	MS CONTIN SR	PFR
02302799	TEVA-MORPHINE SR	TEV

200MG TABLET (EXTENDED RELEASE)

02014327	MS CONTIN SR	PFR
02302802	TEVA-MORPHINE SR	TEV

28:08.08 OPIATE AGONISTS

MORPHINE SULFATE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

5MG TABLET (IMMEDIATE RELEASE)

02014203	MS IR	PFR

10MG TABLET (IMMEDIATE RELEASE)

02014211	MS IR	PFR

20MG TABLET (IMMEDIATE RELEASE)

02014238	MS IR	PFR

30MG TABLET (IMMEDIATE RELEASE)

02014254	MS IR	PFR

MORPHINE SULFATE (KADIAN)

Limited use benefit (prior approval required).

- For the treatment of opioid dependence where methadone and Suboxone are not available or not appropriate; OR
- For the treatment of chronic pain.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG CAPSULE (SUSTAINED RELEASE)

02242163	KADIAN	BGP
09991310	KADIAN	MAY

20MG CAPSULE (SUSTAINED RELEASE)

02184435	KADIAN	BGP
09991311	KADIAN	MAY

50MG CAPSULE (SUSTAINED RELEASE)

02184443	KADIAN	BGP
09991312	KADIAN	MAY

100MG CAPSULE (SUSTAINED RELEASE)

02184451	KADIAN	BGP
09991313	KADIAN	MAY

OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

10MG SUPPOSITORY

00392480	SUPEUDOL	SDZ

20MG SUPPOSITORY

00392472	SUPEUDOL	SDZ

5MG TABLET

02325950	OXYCODONE	PDL
02231934	OXY-IR	PFR
02319977	PMS-OXYCODONE	PMS
00789739	SUPEUDOL	SDZ

10MG TABLET

02325969	OXYCODONE	PDL
02240131	OXY-IR	PFR
02319985	PMS-OXYCODONE	PMS
00443948	SUPEUDOL	SDZ

28:08.08 OPIATE AGONISTS

OXYCODONE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented an opioid dose limit of 200 mg morphine equivalents per day for non-cancer, non-palliative pain. This limit will be calculated based on the total dose of all opioids a client is receiving from NIHB within a 30-day period (i.e. 6000 morphine equivalents over 30 days).

20MG TABLET

02325977	OXYCODONE	PDL
02319993	PMS-OXYCODONE	PMS
02262983	SUPEUDOL	SDZ

20MG TABLET (IMMEDIATE RELEASE)

02240132	OXY-IR	PFR

28:08.12 OPIATE PARTIAL AGONISTS

BUPRENORPHINE HYDROCHLORIDE, NALOXONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of opioid dependence when:
- The client must be 16 years or older.
- In cases where the client lives in a remote or isolated location, confirmation is required that the community has the ability to support Suboxone administration. These supports include the safe daily witnessing, storage and handling of the Suboxone doses. After this confirmation, NIHB will approve the Suboxone for the client.

2MG & 0.5MG TABLET

02408090	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424851	PMS-BUPRENORPHINE-NALOXONE	PMS
02295695	SUBOXONE	IND

8MG & 2MG TABLET

02408104	MYLAN-BUPRENORPHINE/NALOXONE	MYL
02424878	PMS-BUPRENORPHINE-NALOXONE	PMS
02295709	SUBOXONE	IND

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

ST **80MG/ML DROP**

02027801	PEDIATRIX	TEV
00875988	TEMPRA INFANT	PAL

ST **16MG/ML LIQUID**

01905848	ACETAMINOPHEN	TLI
00792713	PDP-ACETAMINOPHEN	PED
02263807	PEDIAPHEN	EUR
00884553	TEMPRA CHILDREN'S	PAL

ST **32MG/ML LIQUID**

01901389	ACETAMINOPHEN	JMP
01958836	ACETAMINOPHEN	TLI
00792691	PDP-ACETAMINOPHEN	PED
02263831	PEDIAPHEN	EUR
02027798	PEDIATRIX	TEV
00875996	TEMPRA CHILDREN'S DOUBLE STRENGTH	PAL
02046040	TYLENOL	MCL

ST **80MG/ML ORAL LIQUID**

01905864	ACETAMINOPHEN	TLI
02046059	TYLENOL	MCL

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

ST **80MG/ML SOLUTION**

01904140	ACETAMINOPHEN	TAN
00887587	PDP-ACETAMINOPHEN	PED
02263793	PEDIAPHEN	EUR

120MG SUPPOSITORY

01919385	ABENOL	PED

325MG SUPPOSITORY

01919393	ABENOL	PED
02230436	ACET 325	PED
02046687	PMS-ACETAMINOPHEN	PMS

650MG SUPPOSITORY

01919407	ABENOL	PED
02230437	ACET 650	PED
02046695	PMS-ACETAMINOPHEN	PMS

ST **80MG TABLET**

01905856	ACETAMINOPHEN	TLI
02015676	ACETAMINOPHEN	TAN
02263815	PEDIAPHEN	EUR
02238295	TYLENOL JR STRENGTH FASTMELTS	MCL

ST **160MG TABLET**

02017431	ACETAMINOPHEN	RIV
02230934	ACETAMINOPHEN	TAN

ST **325MG TABLET**

00382752	ACETAMINOPHEN	PDL
00605751	ACETAMINOPHEN	VTH
00743542	ACETAMINOPHEN	PMT
00789801	ACETAMINOPHEN	TLI
01938088	ACETAMINOPHEN	JMP
02022214	ACÉTAMINOPHÈNE	RIV
02362198	ACÉTAMINOPHÈNE	RIV
00544981	APO ACETAMINOPHEN	APX
02229873	APO-ACETAMINOPHEN	APX
02451018	M-ACETAMINOPHEN	MAN
00389218	NOVO-GESIC	TEV
00559393	TYLENOL	MCL
00723894	TYLENOL	MCL

ST **500MG TABLET**

00386626	ACETAMINOPHEN	PDL
00549703	ACETAMINOPHEN	PMT
00605778	ACETAMINOPHEN	VTH
00789798	ACETAMINOPHEN	TLI
01939122	ACETAMINOPHEN	JMP
01962353	ACETAMINOPHEN	TAN
02252813	ACETAMINOPHEN	PMT
02255251	ACETAMINOPHEN	PMT
02022222	ACÉTAMINOPHÈNE	RIV
02362228	ACÉTAMINOPHÈNE	RIV

28:08.92 MISCELLANEOUS ANALGESICS AND ANTIPYRETICS

ACETAMINOPHEN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on acetaminophen. The limit accumulates against the amount of acetaminophen claimed to the program from plain acetaminophen and/or acetaminophen in combination with opioids such as codeine (i.e. Tylenol® #3) or oxycodone (i.e. Percocet®). A total of 360 grams of acetaminophen is permitted in a 100-day period, for a total daily dose of 3600mg/day.

ST **500MG TABLET**

02362201	ACÉTAMINOPHÈNE BLASON SHIELD	RIV
00545007	APO ACETAMINOPHEN	APX
02229977	APO-ACETAMINOPHEN	APX
00013668	ATASOL FORTE	CHU
02355299	JAMP ACETAMINOPHEN BLAZON	JMP
00482323	NOVO-GESIC FORTE	TEV
00892505	PMS-ACETAMINOPHEN	PMS
00723908	TYLENOL	MCL
00559407	TYLENOL EXTRA STRENGTH	MCL

ST **80MG TABLET (CHEWABLE)**

02017458	ACETAMINOPHEN	RIV
02129957	ACETAMINOPHEN	VTH

ST **160MG TABLET (CHEWABLE)**

02142805	ACETAMINOPHEN	VTH
02263823	PEDIAPHEN	EUR
02347792	TYLENOL JR STRENGTH FASTMELTS	MCL
02241361	TYLENOL JUNIOR STRENGTH	MCL

28:12.08 ANTICONVULSANTS - BENZODIAZEPINES

CLONAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **0.25MG TABLET**

02442027	CLONAZEPAM	SIV
02179660	PMS-CLONAZEPAM	PMS

ST **0.5MG TABLET**

02177889	APO-CLONAZEPAM	APX
02230366	CLONAPAM	VAE
02442035	CLONAZEPAM	SIV
02270641	CO CLONAZEPAM	OBT
02130998	DOM-CLONAZEPAM	DPC
02224100	DOM-CLONAZEPAM-R	DPC
02230950	MYLAN-CLONAZEPAM	MYL
02048701	PMS-CLONAZEPAM	PMS
02207818	PMS-CLONAZEPAM-R	PMS
02311593	PRO-CLONAZEPAM	PDL
02242077	RIVA-CLONAZEPAM	RIV
00382825	RIVOTRIL	HLR
02233960	SANDOZ CLONAZEPAM	SDZ
02239024	TEVA-CLONAZEPAM	TEV

ST **1MG TABLET**

02230368	CLONAPAM	VAE
02442043	CLONAZEPAM	SIV
02270668	CO CLONAZEPAM	OBT
02048728	PMS-CLONAZEPAM	PMS

28:12.08 ANTICONVULSANTS - BENZODIAZEPINES

CLONAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

1MG TABLET

02311607	PRO-CLONAZEPAM	PDL
02233982	SANDOZ CLONAZEPAM	SDZ

2MG TABLET

02177897	APO-CLONAZEPAM	APX
02230369	CLONAPAM	VAE
02442051	CLONAZEPAM	SIV
02270676	CO CLONAZEPAM	OBT
02131013	DOM-CLONAZEPAM	DPC
02230951	MYLAN-CLONAZEPAM	MYL
02048736	PMS-CLONAZEPAM	PMS
02311615	PRO-CLONAZEPAM	PDL
02242078	RIVA-CLONAZEPAM	RIV
00382841	RIVOTRIL	HLR
02233985	SANDOZ CLONAZEPAM	SDZ
02239025	TEVA-CLONAZEPAM	TEV

28:12.92 MISCELLANEOUS ANTICONVULSANTS

ESLICARBAZEPINE ACETATE

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

200MG TABLET

02426862	APTIOM	SPC

400MG TABLET

02426870	APTIOM	SPC

600MG TABLET

02426889	APTIOM	SPC

800MG TABLET

02426897	APTIOM	SPC

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

100MG CAPSULE

02256142	ACT GABAPENTIN	ACG
02244304	APO-GABAPENTIN	APX
02321203	AURO-GABAPENTIN	AUR
02243743	DOM-GABAPENTIN	DPC
02246314	GABAPENTIN	SIV
02353245	GABAPENTIN	SAN
02416840	GABAPENTIN	ACC
02285819	GD-GABAPENTIN	PFI
02361469	JAMP-GABAPENTIN	JMP
02391473	MAR-GABAPENTIN	MAR
02084260	NEURONTIN	PFI

28:12.92 MISCELLANEOUS ANTICONVULSANTS

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

100MG CAPSULE

02243446	PMS-GABAPENTIN	PMS
02310449	PRO-GABAPENTIN	PDL
02319055	RAN-GABAPENTIN	RBY
02251167	RIVA-GABAPENTIN	RIV
02244513	TEVA-GABAPENTIN	TEV

300MG CAPSULE

02256150	ACT GABAPENTIN	ACG
02244305	APO-GABAPENTIN	APX
02321211	AURO-GABAPENTIN	AUR
02243744	DOM-GABAPENTIN	DPC
02246315	GABAPENTIN	SIV
02353253	GABAPENTIN	SAN
02416859	GABAPENTIN	ACC
02285827	GD-GABAPENTIN	PFI
02361485	JAMP-GABAPENTIN	JMP
02391481	MAR-GABAPENTIN	MAR
02084279	NEURONTIN	PFI
02243447	PMS-GABAPENTIN	PMS
02310457	PRO-GABAPENTIN	PDL
02319063	RAN-GABAPENTIN	RBY
02251175	RIVA-GABAPENTIN	RIV
02244514	TEVA-GABAPENTIN	TEV

400MG CAPSULE

02256169	ACT GABAPENTIN	ACG
02244306	APO-GABAPENTIN	APX
02321238	AURO-GABAPENTIN	AUR
02243745	DOM-GABAPENTIN	DPC
02246316	GABAPENTIN	SIV
02353261	GABAPENTIN	SAN
02416867	GABAPENTIN	ACC
02361493	JAMP-GABAPENTIN	JMP
02391503	MAR-GABAPENTIN	MAR
02248261	MYLAN-GABAPENTIN	MYL
02084287	NEURONTIN	PFI
02243448	PMS-GABAPENTIN	PMS
02310465	PRO-GABAPENTIN	PDL
02319071	RAN-GABAPENTIN	RBY
02251183	RIVA-GABAPENTIN	RIV
02244515	TEVA-GABAPENTIN	TEV

600MG TABLET

02293358	APO-GABAPENTIN	APX
02388200	GABAPENTIN	SIV
02392526	GABAPENTIN	ACC
02431289	GABAPENTIN	SAN
02285843	GD-GABAPENTIN	PFI
02402289	JAMP-GABAPENTIN	JMP
02239717	NEURONTIN	PFI

28:12.92 MISCELLANEOUS ANTICONVULSANTS

GABAPENTIN

Limited use benefit (prior approval is not required).

For safety reasons NIHB has implemented a dose limit on gabapentin. The limit accumulates against the amount of gabapentin claimed to the program. A total of 400 grams of gabapentin is permitted in a 100-day period, for a total daily dose of 4000 mg/day.

ST **600MG TABLET**

02255898	PMS-GABAPENTIN	PMS
02310473	PRO-GABAPENTIN	PDL
02259796	RIVA-GABAPENTIN	RIV
02248457	TEVA-GABAPENTIN	TEV

ST **800MG TABLET**

02293366	APO-GABAPENTIN	APX
02388219	GABAPENTIN	SIV
02392534	GABAPENTIN	ACC
02431297	GABAPENTIN	SAN
02402297	JAMP-GABAPENTIN	JMP
02239718	NEURONTIN	PFI
02255901	PMS-GABAPENTIN	PMS
02310481	PRO-GABAPENTIN	PDL
02259818	RIVA-GABAPENTIN	RIV
02247346	TEVA-GABAPENTIN	TEV

LACOSAMIDE

Limited use benefit (prior approval required).

For adjunctive therapy in patients with refractory partial-onset seizures who meet all of the following criteria:
- Are under the care of a physician experienced in the treatment of epilepsy; AND
- Are currently receiving two or more antiepileptic medications; AND
- Have failed or demonstrated intolerance to at least two other antiepileptic medications.

ST **50MG TABLET**

02357615	VIMPAT	UCB

ST **100MG TABLET**

02357623	VIMPAT	UCB

ST **150MG TABLET**

02357631	VIMPAT	UCB

ST **200MG TABLET**

02357658	VIMPAT	UCB

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

ST **25MG CAPSULE**

02402912	ACT PREGABALIN	ACG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02382210	MYLAN-PREGABALIN	MYL
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

ST **25MG CAPSULE**

02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02392801	RAN-PREGABALIN	RBY
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV

ST **50MG CAPSULE**

02402920	ACT PREGABALIN	ACG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02382229	MYLAN-PREGABALIN	MYL
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02392828	RAN-PREGABALIN	RBY
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV

ST **75MG CAPSULE**

02402939	ACT PREGABALIN	ACG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR
02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02382237	MYLAN-PREGABALIN	MYL
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02392836	RAN-PREGABALIN	RBY
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV

ST **150MG CAPSULE**

02402955	ACT PREGABALIN	ACG
02394278	APO-PREGABALIN	APX

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

Limited use benefit (prior approval required).

For the treatment of neuropathic pain in patients who have failed to effectively treat their pain with a tricyclic antidepressant (TCA);
OR
For the treatment of neuropathic pain in patients who have a contraindication or intolerance to a tricyclic antidepressant (TCA).

Coverage is limited to a maximum of 600mg per day.

150MG CAPSULE

02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP
02268450	LYRICA	PFI
02417561	MAR-PREGABALIN	MAR
02424207	MINT-PREGABALIN	MIN
02382245	MYLAN-PREGABALIN	MYL
02359634	PMS-PREGABALIN	PMS
02396521	PREGABALIN	PDL
02403722	PREGABALIN	SIV
02405563	PREGABALIN	SAN
02392844	RAN-PREGABALIN	RBY
02377063	RIVA-PREGABALIN	RIV
02390841	SANDOZ PREGABALIN	SDZ
02361205	TEVA-PREGABALIN	TEV

300MG CAPSULE

02402998	ACT PREGABALIN	ACG
02394294	APO-PREGABALIN	APX
02436019	JAMP-PREGABALIN	JMP
02268485	LYRICA	PFI
02382253	MYLAN-PREGABALIN	MYL
02359642	PMS-PREGABALIN	PMS
02396548	PREGABALIN	PDL
02403730	PREGABALIN	SIV
02405598	PREGABALIN	SAN
02392860	RAN-PREGABALIN	RBY
02377071	RIVA-PREGABALIN	RIV
02390868	SANDOZ PREGABALIN	SDZ
02361248	TEVA-PREGABALIN	TEV

RUFINAMIDE

Limited use benefit (prior approval required).

- For the adjunctive treatment of seizures associated with Lennox-Gastaux syndrome in adults and children 4 years and older when prescribed by a neurologist or experienced specialist.
- Patient has failed or is intolerant to or has contraindications to at least two adjunctive antiepileptic drugs.

100MG TABLET

02369613	BANZEL	EIS

200MG TABLET

02369621	BANZEL	EIS

400MG TABLET

02369648	BANZEL	EIS

28:16.04 ANTIDEPRESSANTS

BUPROPION HYDROCHLORIDE (WELLBUTRIN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage of Wellbutrin XL and Bupropion SR is limited to 300 mg per day. (Note: this product will not be approved for coverage for smoking cessation).

100MG TABLET (EXTENDED RELEASE)

02331616	BUPROPION SR	PDL
02391562	BUPROPION SR	SAN
02325373	PMS-BUPROPION SR	PMS
02285657	RATIO-BUPROPION	TEV
02275074	SANDOZ BUPROPION SR	SDZ

150MG TABLET (EXTENDED RELEASE)

02439654	ACT BUPROPION XL	ACG
02325357	BUPROPION SR	PDL
02391570	BUPROPION SR	SAN
02382075	MYLAN-BUPROPION XL	MYL
02313421	PMS-BUPROPION SR	PMS
02285665	RATIO-BUPROPION	TEV
02275082	SANDOZ BUPROPION SR	SDZ
02237825	WELLBUTRIN SR	VAE
02275090	WELLBUTRIN XL	VAE

300MG TABLET (EXTENDED RELEASE)

02439662	ACT BUPROPION XL	ACG
02382083	MYLAN-BUPROPION XL	MYL
02275104	WELLBUTRIN XL	VAE

BUPROPION HYDROCHLORIDE (ZYBAN)

Limited use benefit with quantity and frequency limits (prior approval is not required).

For smoking cessation:

Coverage is limited to 180 tablets during a one-year period. The year starts on the date the first prescription is filled. Once this quantity has been reached the client is eligible again for coverage for bupropion hydrochloride when one year has elapsed from the day the initial prescription was filled.

150MG TABLET (EXTENDED RELEASE)

02238441	ZYBAN	VAE

28:16.08 ANTIPSYCHOTIC AGENTS

ARIPIPRAZOLE

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:
- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

2MG TABLET

02322374	ABILIFY	OTS

5MG TABLET

02322382	ABILIFY	OTS

10MG TABLET

02322390	ABILIFY	OTS

15MG TABLET

02322404	ABILIFY	OTS

20MG TABLET

02322412	ABILIFY	OTS

30MG TABLET

02322455	ABILIFY	OTS

28:16.08 ANTIPSYCHOTIC AGENTS

ASENAPINE MALEATE

Limited use benefit (prior approval required).

For the acute treatment of manic or mixed episodes associated with bipolar I disorder as either:
- Monotherapy, after a trial of lithium or divalproex sodium has failed or is contraindicated, and trials of two atypical antipsychotic agents have failed due to intolerance or lack of response; OR
- Co-therapy with lithium or divalproex sodium, after trials of two atypical antipsychotic agents have failed due to intolerance or lack of response.

ST **5MG TABLET**

02374803 SAPHRIS FRS

ST **10MG TABLET**

02374811 SAPHRIS FRS

LURASIDONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of schizophrenia and schizoaffective disorders in patients:
- who have intolerance or lack of response to an adequate trial of another antipsychotic agent; OR
- a contraindication to another antipsychotic agent.

ST **20MG TABLET**

02422050 LATUDA SPC

ST **40MG TABLET**

02387751 LATUDA SPC

ST **60MG TABLET**

02413361 LATUDA SPC

ST **80MG TABLET**

02387778 LATUDA SPC

ST **120MG TABLET**

02387786 LATUDA SPC

PALIPERIDONE PALMITATE

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:
- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

50MG/0.5ML SUSPENSION (EXTENDED RELEASE)

02354217 INVEGA SUSTENNA JSO

75MG/0.75ML SUSPENSION (EXTENDED RELEASE)

02354225 INVEGA SUSTENNA JSO

100MG/ML SUSPENSION (EXTENDED RELEASE)

02354233 INVEGA SUSTENNA JSO

150MG/1.5ML SUSPENSION (EXTENDED RELEASE)

02354241 INVEGA SUSTENNA JSO

RISPERIDONE (CONSTA)

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:
- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

12.5MG INJECTION

02298465 RISPERDAL CONSTA JSO

25MG INJECTION

02255707 RISPERDAL CONSTA JSO

28:16.08 ANTIPSYCHOTIC AGENTS

RISPERIDONE (CONSTA)

Limited use benefit (prior approval required).

For the management of manifestations of schizophrenia and related psychotic disorders in patients who have:
- tried oral risperidone or paliperidone and at least one other antipsychotic agent and continue to be inadequately controlled at maximally tolerated doses; OR
- who are currently receiving a conventional depot antipsychotic and are experiencing significant side effects such as extrapyramidal symptoms or tardive dyskinesia; OR
- who have a history of non-adherence to antipsychotic medications resulting in important negative outcomes such as repeated hospitalizations.

ST **37.5MG INJECTION**

02255723	RISPERDAL CONSTA	JSO

ST **50MG INJECTION**

02255758	RISPERDAL CONSTA	JSO

28:20.04 AMPHETAMINES

DEXTROAMPHETAMINE SULFATE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

ST **10MG CAPSULE (SUSTAINED RELEASE)**

01924559	DEXEDRINE SPANSULE	PAL

ST **15MG CAPSULE (SUSTAINED RELEASE)**

01924567	DEXEDRINE SPANSULE	PAL

ST **5MG TABLET**

02443236	APO-DEXTROAMPHETAMINE	APX
01924516	DEXEDRINE	PAL

LISDEXAMFETAMINE DIMESYLATE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

ST **10MG CAPSULE**

02439603	VYVANSE	SHI

ST **20MG CAPSULE**

02347156	VYVANSE	SHI

ST **30MG CAPSULE**

02322951	VYVANSE	SHI

ST **40MG CAPSULE**

02347164	VYVANSE	SHI

ST **50MG CAPSULE**

02322978	VYVANSE	SHI

ST **60MG CAPSULE**

02347172	VYVANSE	SHI

28:20.32 CNS STIMULANTS

METHYLPHENIDATE HYDROCHLORIDE

Limited use benefit (prior approval is not required).

The NIHB Program introduced a dose coverage limit for stimulants on February 25, 2015 as part of a strategy to deal with the potential misuse and abuse of these medications. The stimulant dose coverage limit is set at 150 mg of methylphenidate equivalents* per day for adults and children. This limit is calculated based on the total dose of all stimulants that patients are receiving from NIHB. The Program will continue to monitor the utilization of stimulants and adjust the eligible dose limit as required.

* To convert to methylphenidate equivalents, 1 mg of METHYLPHENIDATE, or LISDEXAMFETAMINE is equal to 0.5 mg DEXTROAMPHETAMINE

ST **5MG TABLET**

02273950	APO-METHYLPHENIDATE	APX
02326221	METHYLPHENIDATE	PDL
02234749	PMS-METHYLPHENIDATE	PMS

ST **10MG TABLET**

02249324	APO-METHYLPHENIDATE	APX
02326248	METHYLPHENIDATE	PDL
00584991	PMS-METHYLPHENIDATE	PMS

ST **20MG TABLET**

02249332	APO-METHYLPHENIDATE	APX
02326256	METHYLPHENIDATE	PDL
00585009	PMS-METHYLPHENIDATE	PMS

ST **18MG TABLET (EXTENDED RELEASE)**

02452731	APO-METHYLPHENIDATE ER	APX
02247732	CONCERTA	JSO
02413728	PMS-METHYLPHENIDATE ER	PMS
02315068	TEVA-METHYLPHENIDATE	TEV

ST **20MG TABLET (EXTENDED RELEASE)**

02266687	APO-METHYLPHENIDATE SR	APX
02320312	SANDOZ METHYLPHENIDATE SR	SDZ

ST **27MG TABLET (EXTENDED RELEASE)**

02452758	APO-METHYLPHENIDATE ER	APX
02250241	CONCERTA	JSO
02413736	PMS-METHYLPHENIDATE ER	PMS
02315076	TEVA-METHYLPHENIDATE	TEV

36MG TABLET (EXTENDED RELEASE)

02452766	APO-METHYLPHENIDATE ER	APX
02247733	CONCERTA	JSO
02413744	PMS-METHYLPHENIDATE ER	PMS
02315084	TEVA-METHYLPHENIDATE	TEV

ST **54MG TABLET (EXTENDED RELEASE)**

02330377	APO-METHYLPHENIDATE ER	APX
02247734	CONCERTA	JSO
02413752	PMS-METHYLPHENIDATE ER	PMS
02315092	TEVA-METHYLPHENIDATE	TEV

28:20.92 MISC ANOREXIGENIC AGENTS & RESPIRATORY & CEREBRAL STIMULANT

CAFFEINE CITRATE

Limited use benefit (prior approval not required).

For children up to 1 year of age

POWDER

00972037	CAFFEINE CITRATE	MDS

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

ALPRAZOLAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **0.25MG TABLET**

01908189	ALPRAZOLAM	PDL
02349191	ALPRAZOLAM	SAN
00865397	APO-ALPRAZ	APX
02400111	JAMP-ALPRAZOLAM	JMP
02137534	MYLAN-ALPRAZOLAM	MYL
02417634	NAT-ALPRAZOLAM	NPH
02404877	RIVA-ALPRAZOLAM	RIV
01913484	TEVA-ALPRAZOLAM	TEV
00548359	XANAX	PFI

ST **0.5MG TABLET**

01908170	ALPRAZOLAM	PDL
02349205	ALPRAZOLAM	SAN
00865400	APO-ALPRAZ	APX
02400138	JAMP-ALPRAZOLAM	JMP
02137542	MYLAN-ALPRAZOLAM	MYL
02417642	NAT-ALPRAZOLAM	NPH
02404885	RIVA-ALPRAZOLAM	RIV
01913492	TEVA-ALPRAZOLAM	TEV
00548367	XANAX	PFI

ST **1MG TABLET**

02248706	ALPRAZOLAM	PDL
02243611	APO-ALPRAZ	APX
02400146	JAMP-ALPRAZOLAM	JMP
02417650	NAT-ALPRAZOLAM	NPH
02404893	RIVA-ALPRAZOLAM	RIV
00723770	XANAX	PFI

ST **2MG TABLET**

02243612	APO-ALPRAZ	APX
02400154	JAMP-ALPRAZOLAM	JMP
02229814	MYLAN-ALPRAZOLAM	MYL
02404907	RIVA-ALPRAZOLAM	RIV
00813958	XANAX TS	PFI

BROMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **1.5MG TABLET**

02177153	APO-BROMAZEPAM	APX

ST **3MG TABLET**

02177161	APO-BROMAZEPAM	APX
02220520	BROMAZEPAM	PDL
00518123	LECTOPAM	HLR
02230584	TEVA-BROMAZEPAM	TEV

ST **6MG TABLET**

02177188	APO-BROMAZEPAM	APX

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

BROMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **6MG TABLET**

02220539	BROMAZEPAM	PDL
00518131	LECTOPAM	HLR
02230585	TEVA-BROMAZEPAM	TEV

DIAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **1MG/ML SOLUTION**

00891797	PMS-DIAZEPAM	PMS

ST **2MG TABLET**

00405329	APO DIAZEPAM	APX
02247490	PMS-DIAZEPAM	PMS

ST **5MG TABLET**

00362158	APO DIAZEPAM	APX
00313580	DIAZEPAM	PDL
02247491	PMS-DIAZEPAM	PMS
00013285	VALIUM	HLR

ST **10MG TABLET**

00405337	APO DIAZEPAM	APX
02247492	PMS-DIAZEPAM	PMS

DIAZEPAM (DIASTAT)

Limited use benefit (prior approval not required).

For children 12 years of age or under.

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4,000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **5MG/ML GEL**

02238162	DIASTAT	VAE
09853340	DIASTAT 2X10MG RECTAL PACK	ELN
09853430	DIASTAT 2X15MG RECTAL PACK	ELN

LORAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **0.5MG TABLET**

00655740	APO-LORAZEPAM	APX
02410745	APO-LORAZEPAM SUBLINGUAL	APX
02041413	ATIVAN	PFI
02041456	ATIVAN SUBLINGUAL	PFI
02245784	DOM-LORAZEPAM	DPC
02351072	LORAZEPAM	SAN
00728187	PMS-LORAZEPAM	PMS
00655643	PRO-LORAZEPAM	PDL
00711101	TEVA-LORAZEPAM	TEV

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

LORAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **1MG TABLET**

00655759	APO-LORAZEPAM	APX
02410753	APO-LORAZEPAM SUBLINGUAL	APX
02041421	ATIVAN	PFI
02041464	ATIVAN SUBLINGUAL	PFI
02245785	DOM-LORAZEPAM	DPC
02351080	LORAZEPAM	SAN
00728195	PMS-LORAZEPAM	PMS
00655651	PRO-LORAZEPAM	PDL
00637742	TEVA-LORAZEPAM	TEV

ST **2MG TABLET**

00655767	APO-LORAZEPAM	APX
02410761	APO-LORAZEPAM SUBLINGUAL	APX
02041448	ATIVAN	PFI
02041472	ATIVAN SUBLINGUAL	PFI
02245786	DOM-LORAZEPAM	DPC
02351099	LORAZEPAM	SAN
00728209	PMS-LORAZEPAM	PMS
00655678	PRO-LORAZEPAM	PDL
00637750	TEVA-LORAZEPAM	TEV

NITRAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **5MG TABLET**

00511528	MOGADON	AAP

ST **10MG TABLET**

00511536	MOGADON	AAP

OXAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **10MG TABLET**

00402680	APO OXAZEPAM	APX
00497754	OXAZEPAM	PDL
00414247	OXPAM	BMI
00568392	RIVA OXAZEPAM	RIV

ST **15MG TABLET**

00402745	APO OXAZEPAM	APX
00497762	OXAZEPAM	PDL
00568406	RIVA OXAZEPAM	RIV

ST **30MG TABLET**

00402737	APO OXAZEPAM	APX
00497770	OXAZEPAM	PDL
00414263	OXPAM	BMI

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

OXAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **30MG TABLET**

00568414	RIVA OXAZEPAM	RIV

TEMAZEPAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **15MG CAPSULE**

02225964	APO-TEMAZEPAM	APX
00604453	RESTORIL	AAP
02229760	TEMAZEPAM	PDL
02230095	TEVA-TEMAZEPAM	TEV

ST **30MG CAPSULE**

02225972	APO-TEMAZEPAM	APX
00604461	RESTORIL	AAP
02229761	TEMAZEPAM	PDL
02230102	TEVA-TEMAZEPAM	TEV

TRIAZOLAM

Limited use benefit (prior approval is not required).

To promote safe, therapeutically effective and efficient use of drug therapy NIHB has implemented a benzodiazepine dose limit of 40 mg diazepam equivalents per day. This limit will be calculated based on the total dose of all benzodiazepines a client is receiving from NIHB within a 100-day period (i.e. 4 000 diazepam equivalents over 100 days). According to the product monograph for diazepam, the recommended usual adult dosage is up to 40 mg per day.

ST **0.25MG TABLET**

00808571	TRIAZOLAM	AAP

28:32.28 SELECTIVE SEROTONIN AGONISTS

ALMOTRIPTAN MALATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

6.25MG TABLET

02405792	APO-ALMOTRIPTAN	APX
02248128	AXERT	MCL
02398435	MYLAN-ALMOTRIPTAN	MYL

12.5MG TABLET

02424029	ALMOTRIPTAN	PDL
02405806	APO-ALMOTRIPTAN	APX
02248129	AXERT	MCL
02398443	MYLAN-ALMOTRIPTAN	MYL
02405334	SANDOZ ALMOTRIPTAN	SDZ

NARATRIPTAN HYDROCHLORIDE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

1MG TABLET

02237820	AMERGE	GSK
02314290	TEVA-NARATRIPTAN	TEV

28:32.28 SELECTIVE SEROTONIN AGONISTS

NARATRIPTAN HYDROCHLORIDE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

2.5MG TABLET

02237821	AMERGE	GSK
02322323	SANDOZ NARATRIPTAN	SDZ
02314304	TEVA-NARATRIPTAN	TEV

RIZATRIPTAN BENZOATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

5MG TABLET

02393468	APO-RIZATRIPTAN	APX
02380455	JAMP-RIZATRIPTAN	JMP
02429233	JAMP-RIZATRIPTAN IR	JMP
02379651	MAR-RIZATRIPTAN	MAR
02428512	VAN-RIZATRIPTAN	VAN

10MG TABLET

02381702	ACT RIZATRIPTAN	ACG
02393476	APO-RIZATRIPTAN	APX
02441144	AURO-RIZATRIPTAN	AUR
02380463	JAMP-RIZATRIPTAN	JMP
02429241	JAMP-RIZATRIPTAN IR	JMP
02379678	MAR-RIZATRIPTAN	MAR
02240521	MAXALT	FRS
02428520	VAN-RIZATRIPTAN	VAN

5MG TABLET (ORALLY DISINTEGRATING)

02374730	ACT RIZATRIPTAN ODT	ACG
02393484	APO-RIZATRIPTAN RPD	APX
02465086	JAMP-RIZATRIPTAN ODT	JMP
02240518	MAXALT RPD	FRS
02379198	MYLAN-RIZATRIPTAN ODT	MYL
02436604	NAT-RIZATRIPTAN ODT	NPH
02393360	PMS-RIZATRIPTAN RDT	PMS
02423456	RIVA-RIZATRIPTAN ODT	RIV
02442906	RIZATRIPTAN ODT	SAN
02446111	RIZATRIPTAN ODT	SIV
02415798	RIZATRIPTAN RDT	PDL
02351870	SANDOZ RIZATRIPTAN ODT	SDZ
02396661	TEVA-RIZATRIPTAN ODT	TEV

10MG TABLET (ORALLY DISINTEGRATING)

02374749	ACT RIZATRIPTAN ODT	ACG
02393492	APO-RIZATRIPTAN RPD	APX
02396203	DOM-RIZATRIPTAN RDT	DPC
02465094	JAMP-RIZATRIPTAN ODT	JMP
02240519	MAXALT RPD	FRS
02379201	MYLAN-RIZATRIPTAN ODT	MYL
02436612	NAT-RIZATRIPTAN ODT	NPH
02393379	PMS-RIZATRIPTAN RDT	PMS
02423464	RIVA-RIZATRIPTAN ODT	RIV
02442914	RIZATRIPTAN ODT	SAN
02446138	RIZATRIPTAN ODT	SIV

28:32.28 SELECTIVE SEROTONIN AGONISTS

RIZATRIPTAN BENZOATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

10MG TABLET (ORALLY DISINTEGRATING)

02415801	RIZATRIPTAN RDT	PDL
02351889	SANDOZ RIZATRIPTAN ODT	SDZ
02396688	TEVA-RIZATRIPTAN ODT	TEV
02448505	VAN-RIZATRIPTAN ODT	VAN

SUMATRIPTAN SUCCINATE

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

6MG/0.5ML INJECTION

99000598	IMITREX STAT DOSE KIT	GSK

12MG/ML SOLUTION

02212188	IMITREX	GSK
02361698	TARO-SUMATRIPTAN	TAR

25MG TABLET

02257882	ACT SUMATRIPTAN	ACG
02270749	DOM-SUMATRIPTAN	DPC
02268906	MYLAN-SUMATRIPTAN	MYL
02256428	PMS-SUMATRIPTAN	PMS
02286815	TEVA-SUMATRIPTAN DF	TEV

50MG TABLET

02257890	ACT SUMATRIPTAN	ACG
02268388	APO-SUMATRIPTAN	APX
02270757	DOM-SUMATRIPTAN	DPC
02212153	IMITREX DF	GSK
02268914	MYLAN-SUMATRIPTAN	MYL
02256436	PMS-SUMATRIPTAN	PMS
02263025	SANDOZ SUMATRIPTAN	SDZ
02286521	SUMATRIPTAN	SAN
02324652	SUMATRIPTAN	PDL
02385570	SUMATRIPTAN DF	SIV
02286823	TEVA-SUMATRIPTAN DF	TEV

100MG TABLET

02257904	ACT SUMATRIPTAN	ACG
02268396	APO-SUMATRIPTAN	APX
02270765	DOM-SUMATRIPTAN	DPC
02212161	IMITREX DF	GSK
02268922	MYLAN-SUMATRIPTAN	MYL
02256444	PMS-SUMATRIPTAN	PMS
02263033	SANDOZ SUMATRIPTAN	SDZ
02286548	SUMATRIPTAN	SAN
02324660	SUMATRIPTAN	PDL
02385589	SUMATRIPTAN DF	SIV
02239367	TEVA-SUMATRIPTAN	TEV
02286831	TEVA-SUMATRIPTAN DF	TEV

28:32.28 SELECTIVE SEROTONIN AGONISTS

ZOLMITRIPTAN

Limited use benefit (prior approval is not required).

A total of 12 tablets (or injections) are permitted in a 30-day period.

2.5MG TABLET

02380951	APO-ZOLMITRIPTAN	APX
02389525	DOM-ZOLMITRIPTAN	DPC
02421623	JAMP-ZOLMITRIPTAN	JMP
02399458	MAR-ZOLMITRIPTAN	MAR
02419521	MINT-ZOLMITRIPTAN	MIN
02369036	MYLAN-ZOLMITRIPTAN	MYL
02421534	NAT-ZOLMITRIPTAN	NPH
02324229	PMS-ZOLMITRIPTAN	PMS
02401304	RIVA-ZOLMITRIPTAN	RIV
02362988	SANDOZ ZOLMITRIPTAN	SDZ
02313960	TEVA-ZOLMITRIPTAN	TEV
02379929	ZOLMITRIPTAN	PDL
02238660	ZOMIG	AZC

2.5MG TABLET (ORALLY DISINTEGRATING)

02438453	AG-ZOLMITRIPTAN ODT	ANG
02381575	APO-ZOLMITRIPTAN RAPID	APX
02428237	JAMP-ZOLMITRIPTAN ODT	JMP
02387158	MYLAN-ZOLMITRIPTAN ODT	MYL
02324768	PMS-ZOLMITRIPTAN ODT	PMS
02362996	SANDOZ ZOLMITRIPTAN ODT	SDZ
02428474	SEPTA-ZOLMITRIPTAN-ODT	SPT
02342545	TEVA-ZOLMITRIPTAN OD	TEV
02438763	VAN-ZOLMITRIPTAN ODT	VAN
02379988	ZOLMITRIPTAN ODT	PDL
02243045	ZOMIG RAPIMELT	AZC

28:36.20 ANTIPARKINSONIAN AGENTS - DOPAMINE RECEPTOR AGONISTS

CABERGOLINE

Limited use benefit (prior approval required).

For treatment of hyperprolactinemia in patients who have failed therapy with or are intolerant to bromocriptine.

0.5MG TABLET

02301407	ACT CABERGOLINE	ACG
02455897	APO-CABERGOLINE	APX
02242471	DOSTINEX	PFI

ROTIGOTINE

Limited use benefit (prior approval required).

As an adjunct to levodopa for the treatment of patients with advanced stage Parkinson's disease, AND
Patient is currently receiving treatment with levodopa.

2MG PATCH

02403900	NEUPRO	UCB

4MG PATCH

02403927	NEUPRO	UCB

6MG PATCH

02403935	NEUPRO	UCB

8MG PATCH

02403943	NEUPRO	UCB

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ACAMPROSATE CALCIUM

Limited use benefit (prior approval required).

For patients who have been abstinent from alcohol for at least four days and where available, are currently enrolled in an alcohol addiction treatment program.

333MG TABLET (DELAYED RELEASE)

02293269	CAMPRAL	MYL

ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:
- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

10MG CAPSULE

02318024	APO-ATOMOXETINE	APX
02358190	ATOMOXETINE	AAP
02396904	ATOMOXETINE	PDL
02445883	ATOMOXETINE	SIV
02390469	DOM-ATOMOXETINE	DPC
02381028	PMS-ATOMOXETINE	PMS
02405962	RIVA-ATOMOXETINE	RIV
02386410	SANDOZ ATOMOXETINE	SDZ
02262800	STRATTERA	LIL
02314541	TEVA-ATOMOXETINE	TEV

18MG CAPSULE

02318032	APO-ATOMOXETINE	APX
02358204	ATOMOXETINE	AAP
02396912	ATOMOXETINE	PDL
02445905	ATOMOXETINE	SIV
02390477	DOM-ATOMOXETINE	DPC
02378930	MYLAN-ATOMOXETINE	MYL
02381036	PMS-ATOMOXETINE	PMS
02386429	SANDOZ ATOMOXETINE	SDZ
02262819	STRATTERA	LIL
02314568	TEVA-ATOMOXETINE	TEV

25MG CAPSULE

02318040	APO-ATOMOXETINE	APX
02358212	ATOMOXETINE	AAP
02396920	ATOMOXETINE	PDL
02445913	ATOMOXETINE	SIV
02390485	DOM-ATOMOXETINE	DPC
02378949	MYLAN-ATOMOXETINE	MYL
02381044	PMS-ATOMOXETINE	PMS
02405989	RIVA-ATOMOXETINE	RIV
02386437	SANDOZ ATOMOXETINE	SDZ
02262827	STRATTERA	LIL
02314576	TEVA-ATOMOXETINE	TEV

40MG CAPSULE

02318059	APO-ATOMOXETINE	APX
02358220	ATOMOXETINE	AAP
02396939	ATOMOXETINE	PDL
02445948	ATOMOXETINE	SIV
02390493	DOM-ATOMOXETINE	DPC

28:92.00 MISCELLANEOUS CENTRAL NERVOUS SYSTEM AGENTS

ATOMOXETINE HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with Attention Deficit Hyperactivity Disorder (ADHD) who meet one of the following criteria:
- Failure or intolerance to methylphenidate or amphetamine; OR
- Contraindication to stimulant medication; OR
- Potential risk of stimulant misuse or diversion; OR
- Prescribed or recommended by a pediatrician or a psychiatrist.

40MG CAPSULE

02378957	MYLAN-ATOMOXETINE	MYL
02381052	PMS-ATOMOXETINE	PMS
02405997	RIVA-ATOMOXETINE	RIV
02386445	SANDOZ ATOMOXETINE	SDZ
02262835	STRATTERA	LIL
02314584	TEVA-ATOMOXETINE	TEV

60MG CAPSULE

02318067	APO-ATOMOXETINE	APX
02358239	ATOMOXETINE	AAP
02396947	ATOMOXETINE	PDL
02445956	ATOMOXETINE	SIV
02390515	DOM-ATOMOXETINE	DPC
02378965	MYLAN-ATOMOXETINE	MYL
02381060	PMS-ATOMOXETINE	PMS
02406004	RIVA-ATOMOXETINE	RIV
02386453	SANDOZ ATOMOXETINE	SDZ
02262843	STRATTERA	LIL
02314592	TEVA-ATOMOXETINE	TEV

80MG CAPSULE

02318075	APO-ATOMOXETINE	APX
02358247	ATOMOXETINE	AAP
02378973	MYLAN-ATOMOXETINE	MYL
02404664	PMS-ATOMOXETINE	PMS
02422824	RIVA-ATOMOXETINE	RIV
02386461	SANDOZ ATOMOXETINE	SDZ
02279347	STRATTERA	LIL
02362511	TEVA-ATOMOXETINE	TEV

100MG CAPSULE

02318083	APO-ATOMOXETINE	APX
02358255	ATOMOXETINE	AAP
02378981	MYLAN-ATOMOXETINE	MYL
02404672	PMS-ATOMOXETINE	PMS
02422832	RIVA-ATOMOXETINE	RIV
02386488	SANDOZ ATOMOXETINE	SDZ
02279355	STRATTERA	LIL
02362538	TEVA-ATOMOXETINE	TEV

32:00 CONTRACEPTIVES (NON-ORAL)

32:00.00 CONTRACEPTIVES (NON-ORAL)

INTRAUTERINE DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 12 months.

DEVICE

00970328	FLEXI-T +300 IUD	TSN

32:00.00 CONTRACEPTIVES (NON-ORAL)

INTRAUTERINE DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 12 months.

DEVICE

00970336	FLEXI-T +380 IUD	TSN
98099999	FLEXI-TD	TSN
99401085	LIBERTE UT380 SHORT IUD	MSF
99401086	LIBERTE UT380 STANDARD IUD	MSF
00970379	MONA LISA 10	SEA
00970387	MONA LISA 5	SEA
00970395	MONA LISA N	SEA
99400482	NOVA-T	BEX

36:00 DIAGNOSTIC AGENTS (DX)

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:
- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

ACCU-CHEK ADVANTAGE STRIP

09853626	ACCU-CHEK ADVANTAGE	ROD
97799824	ACCU-CHEK ADVANTAGE	ROD

ACCU-CHEK AVIVA STRIP

09857178	ACCU-CHEK AVIVA	ROD
97799814	ACCU-CHEK AVIVA	ROD

ACCU-CHEK COMPACT STRIP

09854282	ACCU-CHEK COMPACT	ROD
97799962	ACCU-CHEK COMPACT	ROD

ACCU-CHEK MOBILE STRIP

09857452	ACCU-CHEK MOBILE BG	ROD
97799497	ACCU-CHEK MOBILE CASSETT	ROD

ACCUTREND STRIP

09853162	ACCUTREND	ROD
97799959	ACCUTREND	ROD

ASCENSIA BREEZE 2 STRIP

97799748	ASCENSIA BREEZE 2	BAY
09857293	BREEZE 2 BG (ON)	BAY

ASCENSIA CONTOUR STRIP

97799702	ASCENCIA CONTOUR	BAY
09857127	CONTOUR BG (ON)	BAY

BG STAR STRIP

97799465	BG STAR	SAC
09857422	BG STAR (ON)	SAC

CONTOUR NEXT STRIP

97799459	CONTOUR NEXT	BAY
09857453	CONTOUR NEXT (ON)	BAY

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:
- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

EZ HEALTH STRIP		
09857357	EZ HEALTH ORACLE	TRE
97799564	EZ HEALTH ORACLE	TRE
FREESTYLE STRIP		
97799829	FREESTYLE	ABB
09857141	FREESTYLE (ON)	ABB
FREESTYLE LITE STRIP		
97799597	FREESTYLE LITE	ABB
09857297	FREESTYLE LITE (ON)	ABB
FREESTYLE PRECISION STRIP		
97799346	FREESTYLE PRECISION	ABB
09857502	FREESTYLE PRECISION (ON)	ABB
GE200 STRIP		
97799373	GE200	AUC
09857525	GE200 (ON)	AUC
ITEST STRIP		
09857348	ITEST	AUC
97799692	ITEST	AUC
MEDI+SURE STRIP		
97799403	MEDI+SURE	MEC
09857432	MEDI+SURE (ON)	MEC
NOVA MAX STRIP		
09857313	NOVA MAX	NCA
ONE TOUCH ULTRA STRIP		
09854290	ONE TOUCH ULTRA	JAJ
97799985	ONE TOUCH ULTRA	JAJ
ONE TOUCH VERIO STRIP		
97799475	ONETOUCH VERIO	JAJ
09857392	ONETOUCH VERIO (ON)	JAJ
PRECISION XTRA STRIP		
09854070	PRECISION XTRA	ABB
97799840	PRECISION XTRA	AUC
SIDEKICK STRIP		
97799601	SIDEKICK	HOD
SPIRIT STRIP		
97799291	FIRST CANHEALTH SPIRIT	ARA
09857547	SPIRIT TEST STRIP (ON)	ARA
SURE STEP STRIP		
97799355	SURE STEP	SKY
SURETEST STRIP		
09857522	SURETEST (ON)	SKY

36:26.00 DX - DIABETES MELLITUS

GLUCOSE OXIDASE, PEROXIDASE

Limited use benefit (prior approval not required).

The number of test strips that will be covered by the NIHB Program will depend on the client's medical treatment:
- Clients managing diabetes with insulin will be allowed 500 test strips per 100 days. A client can test up to five times per day.
- Clients managing diabetes with diabetes medication with a high risk of causing low blood sugar will be allowed 400 test strips per 365 days. A client can test once daily.
- Clients managing diabetes with diabetes medication with a low risk of causing low blood sugar will be allowed 200 test strips per 365 days. A client can test three to four times per week.
- Clients managing diabetes with diet/lifestyle therapy only (no insulin or diabetes medications) will be allowed 200 test strips per 365 days. A client can test three to four times per week.

TRUETEST STRIP

97799532	TRUETEST	HOD

TRUETRACK STRIP

09857283	TRUE TRACK	AUC
97799602	TRUE TRACK	HOD

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:18.19 PHOSPHATE - REMOVING AGENTS

LANTHANUM CARBONATE HYDRATE

Limited use benefit (prior approval required).

For patients with elevated phosphate levels OR elevated phosphate X calcium product despite dietary restriction of phosphate and use of calcium-based phosphate binders (short term elevations should be managed with aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

250MG TABLET (CHEWABLE)

02287145	FOSRENOL	SHI

500MG TABLET (CHEWABLE)

02287153	FOSRENOL	SHI

750MG TABLET (CHEWABLE)

02287161	FOSRENOL	SHI

1000MG TABLET (CHEWABLE)

02287188	FOSRENOL	SHI

SEVELAMER HYDROCHLORIDE

Limited use benefit (prior approval required).

For patients with elevated phosphate levels OR elevated phosphate X calcium product despite dietary restriction of phosphate and use of calcium-based phosphate binders (short term elevations should be managed with aluminium based binders).

For patients with elevated calcium levels despite discontinuation of calcium binder, and Vitamin D analogue and/or modification of dialysate calcium.

For patients with adynamic bone disease and low PTH levels (<100 pg/ml or <0.9 pmol/L) with normal or elevated calcium levels.

800MG TABLET

02244310	RENAGEL	SAC

40:20.00 CALORIC AGENTS

LEVOCARNITINE

Limited use benefit (prior approval required).

For treatment of camitine deficiency.

100MG/ML SOLUTION

02144336	CARNITOR	UNK

200MG/ML SOLUTION

02144344	CARNITOR	UNK

330MG TABLET

02144328	CARNITOR	UNK

48:00 RESPIRATORY TRACT AGENTS

48:02.00 ANTIFIBROTIC AGENTS

NINTEDANIB ESILATE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 week allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

100MG CAPSULE

02443066	OFEV	BOE

150MG CAPSULE

02443074	OFEV	BOE

PIRFENIDONE

Limited use benefit (prior approval required).

Initial Request - Coverage is provided for a period of 7 months (6 months plus a 4 weeks allowance for repeat pulmonary function tests):

For the treatment of adult patients with a diagnosis of mild to moderate idiopathic pulmonary fibrosis (IPF) who meet the following criteria:
- Diagnosis confirmed by a respirologist and a high-resolution CT scan within the previous 24 months; AND
- All other causes of restrictive lung disease (e.g. collagen vascular disorder or hypersensitivity pneumonitis) should be excluded; AND
- Mild to moderate IPF is defined as forced vital capacity (FVC) greater than or equal to 50% of predicted; AND
- Patient is under the care of a physician with experience in IPF.

Renewal at 6 months - Coverage is provided for a period of 6 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% from initiation of therapy until renewal (initial 6 month treatment period). If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Subsequent Renewals at 12 months and thereafter - Coverage is provided for a period of 12 months:
- Patients must NOT demonstrate progression of disease defined as an absolute decline in percent predicted FVC of ≥ 10% within any 12 month period. If a patient has experienced progression as defined above, then the results should be validated with a confirmatory pulmonary function test conducted 4 weeks later.

Combination use of Ofev (nintedanib) and Esbriet (pirfenidone) will not be provided.

267MG CAPSULE

02393751	ESBRIET	HLR

48:10.24 LEUKOTRIENE MODIFIERS

MONTELUKAST SODIUM

Limited use benefit (prior approval required).

For treatment of:
- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **4MG GRANULES**

02358611	SANDOZ MONTELUKAST	SDZ
02247997	SINGULAIR	FRS

ST **10MG TABLET**

02374609	APO-MONTELUKAST	APX
02401274	AURO-MONTELUKAST	AUR
02376695	DOM-MONTELUKAST	DPC
02391422	JAMP-MONTELUKAST	JMP

48:10.24 LEUKOTRIENE MODIFIERS

MONTELUKAST SODIUM

Limited use benefit (prior approval required).

For treatment of:
- asthma when used in patients on concurrent steroid therapy; OR
- asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **10MG TABLET**

02399997	MAR-MONTELUKAST	MAR
02408643	MINT-MONTELUKAST	MIN
02379333	MONTELUKAST	SAN
02379856	MONTELUKAST	PDL
02382474	MONTELUKAST	SIV
02379236	MONTELUKAST SODIUM	ACC
02368226	MYLAN-MONTELUKAST	MYL
02373947	PMS-MONTELUKAST	PMS
02389517	RAN-MONTELUKAST	RBY
02398826	RIVA-MONTELUKAST	RIV
02328593	SANDOZ MONTELUKAST	SDZ
02238217	SINGULAIR	FRS
02355523	TEVA-MONTELUKAST	TEV

4MG TABLET (CHEWABLE)

02377608	APO-MONTELUKAST	APX
02422867	AURO-MONTELUKAST	AUR
02442353	JAMP-MONTELUKAST	JMP
02399865	MAR-MONTELUKAST	MAR
02408627	MINT-MONTELUKAST	MIN
02379317	MONTELUKAST	SAN
02379821	MONTELUKAST	PDL
02382458	MONTELUKAST	SIV
02354977	PMS-MONTELUKAST	PMS
02402793	RAN-MONTELUKAST	RBY
02330385	SANDOZ MONTELUKAST	SDZ
02243602	SINGULAIR	FRS
02355507	TEVA-MONTELUKAST	TEV

ST **5MG TABLET (CHEWABLE)**

02377616	APO-MONTELUKAST	APX
02422875	AURO-MONTELUKAST	AUR
02442361	JAMP-MONTELUKAST	JMP
02399873	MAR-MONTELUKAST	MAR
02408635	MINT-MONTELUKAST	MIN
02379325	MONTELUKAST	SAN
02379848	MONTELUKAST	PDL
02382466	MONTELUKAST	SIV
02380757	MYLAN-MONTELUKAST	MYL
02354985	PMS-MONTELUKAST	PMS
02402807	RAN-MONTELUKAST	RBY
02330393	SANDOZ MONTELUKAST	SDZ
02238216	SINGULAIR	FRS
02355515	TEVA-MONTELUKAST	TEV

48:10.24 LEUKOTRIENE MODIFIERS

ZAFIRLUKAST

Limited use benefit (prior approval required).

For treatment of asthma when used in patients on concurrent steroid therapy.

For asthma patients not well controlled with or intolerant to inhaled corticosteroids.

ST **20MG TABLET**

02236606	ACCOLATE	AZC

48:48.00 VASODILATING AGENTS

BOSENTAN MONOHYDRATE

Limited use benefit (prior approval required).

Maximum dose covered is 125 mg twice daily

Patients with World Health Organization (WHO) class III pulmonary artery hypertension (PAH), either idiopathic (i.e. primary) or associated with a congenital or systemic condition (e.g. connective tissue disease) and confirmed by right heart catheterization; AND
- who have failed to respond to sildenafil OR tadalafil; OR
- who have contraindications to sildenafil OR tadalafil.

ST **125MG TABLET**

02399210	APO-BOSENTAN	APX

48:92.00 MISCELLANEOUS RESPIRATORY TRACT AGENTS

OMALIZUMAB

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections over a 24 week period).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU) who remain symptomatic (presence of hives and/or associated itching) despite optimum management with H1 antihistamines; AND
Prescriber is experienced in the treatment of CIU (Allergist, Dermatologist, Immunologist, OR other authorized prescriber experienced in the treatment of CIU).

Treatment cessation could be considered for patients who experience complete symptom control (UAS-7 = 0) for at least 12 consecutive weeks at the end of a 24-week treatment period.

Renewal coverage is provided for 24 weeks at a maximum dose of 300 mg every 4 weeks (6 injections/24 weeks).

For the treatment of adults and adolescents (12 years of age or older) with moderate to severe chronic idiopathic urticaria (CIU);
AND
Patient stopped omalizumab after achieving complete symptom control (UAS-7 = 0) for at least 12 weeks while on treatment, but has experienced symptom relapse; OR
Patient achieved complete symptom control, but for a period of less than 12 consecutive weeks; OR
Patient achieved a partial response to treatment, defined as a ≥ 9.5-point reduction in baseline urticaria activity score over 7 days (UAS-7).

In patients where treatment is discontinued due to temporary symptom control, treatment re-initiation may be considered should CIU symptoms reappear.

150MG POWDER FOR SOLUTION

02260565	XOLAIR	NVR

52:00 EYE, EAR, NOSE AND THROAT (EENT) PREPARATIONS

52:28.00 EENT - MOUTHWASHES AND GARGLES

BENZYDAMINE HYDROCHLORIDE

Limited use benefit (prior approval required).

- For the treatment of radiation mucositis and oral ulcerative complications of chemotherapy.
- For use in immunocompromised patients who are at risk of mucosal breakdown.

0.15% MOUTHWASH

02239044	APO-BENZYDAMINE	APX
02229777	PHARIXIA	PED
02239537	PMS-BENZYDAMINE	PMS

52:92.00 MISCELLANEOUS EENT DRUGS

AFLIBERCEPT

Limited use benefit (prior approval required).

For the treatment of:
Diabetic Macular Edema (DME)
Wet Age-Related Macular Degeneration (w-AMD)
Retinal Vein Occlusion (RVO)

Criteria for coverage of aflibercept (Eylea) for DME, RVO and w-AMD:
- Administered by a qualified ophthalmologist experienced in intravitreal injections
- Interval between doses not shorter than 1 month

Note: Coverage will be limited to a maximum of 1 vial of Eylea per eye treated every 30 days

1. For the treatment of diabetic macular edema (DME) for patients who meet the following:
- Clinically significant diabetic macular edema for whom laser photocoagulation is also indicated; AND
- Have a hemoglobin A1c of less than 12%

2. Initial Coverage for the treatment of neovascular wet age-related macular degeneration (wAMD) where all of the following apply to the eye to be treated:
- Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96
- The lesion size is less than or equal to 12 disc areas in greatest linear dimension
- There is evidence of recent (< 3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or optical coherence tomography (OCT))

Note: Coverage will not be approved for patients:
- With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.
- Receiving concurrent treatment with verteporfin

Continued Coverage:
Treatment with Eylea for wAMD should be continued only in people who maintain adequate response to therapy

Treatment with Eylea should be permanently discontinued if any one of the following occurs:
- Reduction in BCVA in the treated eye to less than 15 letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology
- Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events or both.
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits.

3. For the treatment of RVO for patients who meet one of the following:
- Clinically significant macular edema secondary to branch retinal vein occlusion (BRVO); OR
- Central retinal vein occlusion (CRVO).
- It is recommended that Eylea be administered once every month. The interval between two doses should not be shorter than one month. The treatment interval may be extended up to 3 months based on visual and anatomic outcomes. Prescribers are advised to periodically assess (every 1 to 2 months) the need for continued therapy.
- Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

40MG SOLUTION

02415992	EYLEA	BAY

52:92.00 MISCELLANEOUS EENT DRUGS

RANIBIZUMAB

Limited use benefit (prior approval required).

For the treatment of:
Diabetic Macular Edema (DME)
Wet Age-Related Macular Degeneration (w-AMD)
Retinal Vein Occlusion (RVO)
Choroidal Neovascularization secondary to pathologic myopia (mCNV)

Criteria for coverage of ranibizumab (Lucentis) for DME, RVO, mCNV and w-AMD:
- Administered by a qualified ophthalmologist experienced in intravitreal injections
- Interval between doses not shorter than 1 month

Note: Coverage will be limited to a maximum of 1 vial of Lucentis per eye treated every 30 days

1. For the treatment of diabetic macular edema (DME) for patients who meet the following:
- Clinically significant diabetic macular edema for whom laser photocoagulation is also indicated; AND
- Have a hemoglobin A1c of less than 11%

2. Initial Coverage for the treatment of neovascular wet age-related macular degeneration (wAMD) where all of the following apply to the eye to be treated:
- Best Corrected Visual Acuity (BCVA) is between 6/12 and 6/96
- The lesion size is less than or equal to 12 disc areas in greatest linear dimension
- There is evidence of recent (< 3 months) presumed disease progression (blood vessel growth, as indicated by fluorescein angiography, or optical coherence tomography (OCT))

Note: Coverage will not be approved for patients:
- With permanent retinal damage as defined by the Royal College of Ophthalmology guidelines.
- Receiving concurrent treatment with verteporfin

Continued Coverage:
Treatment with Lucentis for wAMD should be continued only in people who maintain adequate response to therapy

Treatment with Lucentis should be permanently discontinued if any one of the following occurs:
- Reduction in BCVA in the treated eye to less than 15 letters (absolute) on two (2) consecutive visits in the treated eye, attributed to AMD in the absence of other pathology
- Reductions in BCVA of 30 letters or more compared to either baseline and/or best recorded level since baseline as this may indicate either poor treatment effect, adverse events or both.
- There is evidence of deterioration of the lesion morphology despite optimum treatment over three (3) consecutive visits.

3. For the treatment of RVO for patients who meet one of the following:
- Clinically significant macular edema secondary to branch retinal vein occlusion (BRVO); OR
- Central retinal vein occlusion (CRVO).
- Treatment to be given monthly and continued until maximum visual acuity is achieved, confirmed by stable visual acuity for three consecutive monthly assessments performed while on ranibizumab treatment. Thereafter patients should be monitored monthly for visual acuity.
- Treatment is resumed with monthly injections when monitoring indicates a loss of visual acuity due to macular edema secondary to retinal vein occlusion and continued until stable visual acuity is reached again for three consecutive monthly assessments.
- Treatment with anti-VEGF agents should only be continued in patients who maintain adequate response to therapy.

4. For the treatment of mCNV for patients who meet the following:
- Visual impairment due to choroidal neovascularization secondary to pathologic myopia (mCNV).

Treatment is initiated with a single intravitreal injection. Monitoring is recommended monthly for the first two months and at least every three months thereafter during the first year. If monitoring reveals signs of disease activity (e.g. reduced visual acuity and/or signs of lesion activity), further treatment is recommended at a frequency of 1 injection per month until no disease activity is seen.

10MG/ML SOLUTION

02296810	LUCENTIS	NVR
02425629	LUCENTIS PFS	NVR

VERTEPORFIN

Limited use benefit (prior approval required).

For treatment of age related macular degeneration for patients with this diagnosis who are being treated by a certified ophthalmologist.

15MG/VIAL POWDER FOR SOLUTION

02242367	VISUDYNE	VAE

56:00 GASTROINTESTINAL DRUGS

56:04.00 ANTACIDS AND ADSORBENTS

BISMUTH SUBSALICYLATE

Limited use benefit (prior approval not required).

Coverage will be limited to 8 tablets a day every 14 days, followed by a 28 day lockout;
OR
Coverage will be limited to 120mL a day every 14 days, followed by a 28 day lockout.

262MG CAPLET

00245730	BISMUTH	JMP

17.6MG/ML LIQUID

02097079	PEPTO BISMOL	PGI

262MG TABLET

02326582	BISMUTH SUBSALICYLATE	UNK
02177994	PEPTO BISMOL	PGI

56:22.08 ANTIHISTAMINES

DIMENHYDRINATE

Limited use benefit (prior approval not required).

The NIHB Program implemented a dose coverage limit for DIMENHYDRINATE in June 2017 as part of a strategy to address safety concerns and potential misuse.

The dimenhydrinate dose limit is currently 400 mg per day for a total of 12,000 mg of dimenhydrinate in a 30-day period.

This limit applies only to the 15 mg and 50 mg tablets. Dimenhydrinate in liquid, suppository and injectable forms are not included in this limit.

ST **50MG TABLET**

00363766	APO DIMENHYDRINATE	APX
00013803	GRAVOL	CHU
02245416	JAMP-DIMENHYDRINATE	JMP
02377179	MOTION SICKNESS	APX
00586331	PMS-DIMENHYDRINATE	PMS
00605786	TRAVEL	VTH
00021423	TRAVEL ON	NOP

56:22.32 MISCELLANEOUS ANTIEMETICS

APREPITANT

Limited use benefit (prior approval required).

When used in combination with a 5-HT3 antagonist and dexamethasone for the prevention of acute and delayed nausea and vomiting due to highly emetogenic cancer chemotherapy (e.g. Cisplatin > 70mg/m2).

ST **80MG CAPSULE**

02298791	EMEND	FRS

ST **125MG CAPSULE**

02298805	EMEND	FRS

ST **125MG & 80MG CAPSULE**

02298813	EMEND TRI-PACK	FRS

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;
OR
Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

0.25MG CAPSULE

02312263	CESAMET	VAE
02358077	RAN-NABILONE	RBY
02392925	TEVA-NABILONE	TEV

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

Limited use benefit (prior approval required).

For patients who are experiencing nausea and vomiting due to cancer chemotherapy or radiation;
OR
Patient is palliative (diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less).

0.5MG CAPSULE

02393581	ACT NABILONE	ACG
02256193	CESAMET	VAE
02380900	PMS-NABILONE	PMS
02358085	RAN-NABILONE	RBY
02384884	TEVA-NABILONE	TEV

1MG CAPSULE

02393603	ACT NABILONE	ACG
00548375	CESAMET	VAE
02380919	PMS-NABILONE	PMS
02358093	RAN-NABILONE	RBY
02384892	TEVA-NABILONE	TEV

56:28.36 PROTON-PUMP INHIBITORS

LANSOPRAZOLE

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
- All PPIs are equally efficacious
- Double dose PPI is not necessary for initial therapy
- Double dose PPI is effective in H. Pylori eradication; however, treatment is not needed beyond 14 days.

PPI use has been associated with increased risk of hip fracture, community-acquired pneumonia and Clostridium difficile associated diarrhea. Although further study is needed to establish clinical significance, it is prudent to use the lowest dose and shortest duration of therapy required to control symptoms.

All proton pump inhibitors (open benefit and limited use (LU) PPIs) have a maximum quantity limit of 400 tablets/capsules per 180 day period. This quantity limit will be in effect for the entire class of PPIs.
- For example, if a patient fills 30 tablets of rabeprazole, then switch to 30 tablets of omeprazole, then switch to 30 capsules of lansoprazole, this will count as 90 PPI tablets/capsules towards the quantity limit.
- Patients taking two rabeprazole 10mg tablets a day can be switched to one rabeprazole 20mg tablet a day to avoid reaching the quantity limit
- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

ST **15MG CAPSULE (DELAYED RELEASE)**

02293811	APO-LANSOPRAZOLE	APX
02357682	LANSOPRAZOLE	SAN
02385767	LANSOPRAZOLE	SIV
02433001	LANSOPRAZOLE	PMS
02353830	MYLAN-LANSOPRAZOLE	MYL
02395258	PMS-LANSOPRAZOLE	PMS
02165503	PREVACID	TAK
02402610	RAN-LANSOPRAZOLE	RBY
02422808	RIVA-LANSOPRAZOLE	RIV
02385643	SANDOZ LANSOPRAZOLE	SDZ
02280515	TEVA-LANSOPRAZOLE	TEV

ST **30MG CAPSULE (DELAYED RELEASE)**

02293838	APO-LANSOPRAZOLE	APX
02414775	DOM-LANSOPRAZOLE	DPC
02357690	LANSOPRAZOLE	SAN
02366282	LANSOPRAZOLE	PDL
02410389	LANSOPRAZOLE	SIV

56:28.36 PROTON-PUMP INHIBITORS

LANSOPRAZOLE

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
- All PPIs are equally efficacious
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- Patients taking two omeprazole 10mg tablets/capsules a day can be switched to one omeprazole 20mg tablet/capsule a day to avoid reaching the quantity limit

Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

ST **30MG CAPSULE (DELAYED RELEASE)**

02433028	LANSOPRAZOLE	PMS
02353849	MYLAN-LANSOPRAZOLE	MYL
02395266	PMS-LANSOPRAZOLE	PMS
02165511	PREVACID	TAK
02402629	RAN-LANSOPRAZOLE	RBY
02422816	RIVA-LANSOPRAZOLE	RIV
02280523	TEVA-LANSOPRAZOLE	TEV

ST **30MG TABLET (DELAYED RELEASE)**

02385651	SANDOZ LANSOPRAZOLE	SDZ

LANSOPRAZOLE ODT

Limited use benefit (prior approval required).

Coverage will be limited to 400 tablets/capsules every 180 days.

For children 12 years of age or under who are unable to swallow the capsule formulation; OR
For patients with dysphagia or a feeding tube when the use of the capsule formulation is not possible.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
- All PPIs are equally efficacious
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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

ST **15MG TABLET (DELAYED RELEASE)**

02249464	PREVACID FASTAB	TAK

ST **30MG TABLET (DELAYED RELEASE)**

02249472	PREVACID FASTAB	TAK

56:28.36 PROTON-PUMP INHIBITORS

OMEPRAZOLE MAGNESIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
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20MG CAPSULE (DELAYED RELEASE)

02245058	APO-OMEPRAZOLE	APX
00846503	LOSEC	AZC
02329433	MYLAN-OMEPRAZOLE	MYL
02339927	OMEPRAZOLE	PDL
02348691	OMEPRAZOLE	SAN
02385384	OMEPRAZOLE	SIV
02411857	OMEPRAZOLE-20	SIV
02320851	PMS-OMEPRAZOLE	PMS
02403617	RAN-OMEPRAZOLE	RBY
02296446	SANDOZ OMEPRAZOLE	SDZ

20MG TABLET (DELAYED RELEASE)

02333430	DOM-OMEPRAZOLE DR	DPC
02420198	JAMP-OMEPRAZOLE DR	JMP
02190915	LOSEC	AZC
02439549	NAT-OMEPRAZOLE DR	NPH
02416549	OMEPRAZOLE	ACC
02310260	PMS-OMEPRAZOLE	PMS
02374870	RAN-OMEPRAZOLE	RBY
02260867	RATIO-OMEPRAZOLE	TEV
02402416	RIVA-OMEPRAZOLE DR	RIV
02295415	TEVA-OMEPRAZOLE	TEV
02432404	VAN-OMEPRAZOLE	VAN

56:28.36 PROTON-PUMP INHIBITORS

PANTOPRAZOLE MAGNESIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

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40MG TABLET (DELAYED RELEASE)

02466147	PANTOPRAZOLE T	SAN

40MG TABLET (ENTERIC COATED)

02408570	MYLAN-PANTOPRAZOLE T	MYL
02441853	PANTOPRAZOLE MAGNESIUM	UNK
02267233	TECTA	TAK
02440628	TEVA-PANTOPRAZOLE MAGNESIUM	TEV

PANTOPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

40MG TABLET (DELAYED RELEASE)

02300486	ACT PANTOPRAZOLE	ACG
02292920	APO-PANTOPRAZOLE	APX
02415208	AURO-PANTOPRAZOLE	AUR
02310007	DOM-PANTOPRAZOLE	DPC
02357054	JAMP-PANTOPRAZOLE	JMP
02416565	MAR-PANTOPRAZOLE	MAR
02417448	MINT-PANTOPRAZOLE	MIN
02299585	MYLAN-PANTOPRAZOLE	MYL
02229453	PANTOLOC	TAK
02318695	PANTOPRAZOLE	PDL
02370808	PANTOPRAZOLE	SAN
02431327	PANTOPRAZOLE	RIV

56:28.36 PROTON-PUMP INHIBITORS

PANTOPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

40MG TABLET (DELAYED RELEASE)

02437945	PANTOPRAZOLE	PMS
02428180	PANTOPRAZOLE-40	SIV
02307871	PMS-PANTOPRAZOLE	PMS
02425378	PRIVA-PANTOPRAZOLE	PHA
02305046	RAN-PANTOPRAZOLE	RBY
02316463	RIVA-PANTOPRAZOLE	RIV
02301083	SANDOZ PANTOPRAZOLE	SDZ
02285487	TEVA-PANTOPRAZOLE	TEV

RABEPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

10MG TABLET (ENTERIC COATED)

02345579	APO-RABEPRAZOLE	APX
02408392	MYLAN-RABEPRAZOLE	MYL
02243796	PARIET	JSO
02310805	PMS-RABEPRAZOLE	PMS
02315181	PRO-RABEPRAZOLE	PDL
02385449	RABEPRAZOLE	SIV
02356511	RABEPRAZOLE EC	SAN
02298074	RAN-RABEPRAZOLE	RBY
02330083	RIVA-RABEPRAZOLE EC	RIV
02314177	SANDOZ RABEPRAZOLE	SDZ

56:28.36 PROTON-PUMP INHIBITORS

RABEPRAZOLE SODIUM

Limited use benefit (prior approval not required).

Coverage will be limited to 400 tablets/capsules every 180 days.

The following PPI status change is primarily based on the Canadian Optimal Medication Prescribing and Utilization Service (COMPUS) report on optimal PPI therapy. The report concluded that:
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Patients with Zollinger Ellison Syndrome, Barrett's esophagus, erosive esophagitis and those who remain symptomatic on a single dose PPI will be eligible for additional doses above 400 tablets/capsules per 180 days through the prior approval process.

ST **10MG TABLET (ENTERIC COATED)**

02296632	TEVA-RABEPRAZOLE	TEV

ST **20MG TABLET (ENTERIC COATED)**

02345587	APO-RABEPRAZOLE	APX
02320460	DOM-RABEPRAZOLE EC	DPC
02243797	PARIET	JSO
02310813	PMS-RABEPRAZOLE	PMS
02315203	PRO-RABEPRAZOLE	PDL
02385457	RABEPRAZOLE	SIV
02356538	RABEPRAZOLE EC	SAN
02298082	RAN-RABEPRAZOLE	RBY
02330091	RIVA-RABEPRAZOLE	RIV
02314185	SANDOZ RABEPRAZOLE	SDZ
02296640	TEVA-RABEPRAZOLE	TEV

56:92.00 MISCELLANEOUS GI DRUGS

PINAVERIUM BROMIDE

Limited use benefit (prior approval required).

For the treatment and relief of symptoms associated with functional bowel disorders including Irritable Bowel Syndrome (IBS), spastic colon, spastic colitis and mucous colitis; OR
In postoperative paralytic ileus in order to accelerate the resumption of the intestinal transit following abdominal surgery.

50MG CAPSULE

00465240	DICETEL	SPH

50MG TABLET

01950592	DICETEL	BGP

100MG TABLET

02230684	DICETEL	BGP

68:00 HORMONES AND SYNTHETIC SUBSTITUTES

68:12.00 CONTRACEPTIVES

LEVONORGESTREL INTRAUTERINE INSERT

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 2 years.

13.5MG INSERT (EXTENDED-RELEASE)

02408295	JAYDESS	BAY

68:12.00 CONTRACEPTIVES

LEVONORGESTREL INTRAUTERINE INSERT

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 1 device every 2 years.

52MG INSERT (EXTENDED-RELEASE)

02243005	MIRENA	BAY

ULIPRISTAL ACETATE

Limited use benefit (prior approval not required).

Coverage will be limited to 90 tablets, benefits only for women age 18 to 60 years.

ST **5MG TABLET**

02408163	FIBRISTAL	ALL

68:16.12 ESTROGEN AGONISTS-ANTAGONISTS

RALOXIFENE HYDROCHLORIDE

Limited use benefit (prior approval required).

For secondary prevention of osteoporosis in women who experience failure on bisphosphonates.
For secondary prevention of osteoporosis in women who have a personal history or a first degree relative with a history of breast cancer.

60MG TABLET

02358840	ACT RALOXIFENE	ACG
02279215	APO-RALOXIFENE	APX
02239028	EVISTA	LIL
02358921	PMS-RALOXIFENE	PMS
02415852	RALOXIFENE	PDL
02312298	TEVA-RALOXIFENE	TEV

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

LINAGLIPTIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **5MG TABLET**

02370921	TRAJENTA	BOE

LINAGLIPTIN, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **2.5MG & 1000MG TABLET**

02403277	JENTADUETO	BOE

ST **2.5MG & 500MG TABLET**

02403250	JENTADUETO	BOE

ST **2.5MG & 850MG TABLET**

02403269	JENTADUETO	BOE

SAXAGLIPTIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who: did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **2.5MG TABLET**

02375842	ONGLYZA	AZC

ST **5MG TABLET**

02333554	ONGLYZA	AZC

68:20.05 DIPEPTIDYL PEPTIDASE-4 (DPP-4) INHIBITORS

SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **2.5MG & 1000MG TABLET**

02389185	KOMBOGLYZE	AZC

ST **2.5MG & 500MG TABLET**

02389169	KOMBOGLYZE	AZC

ST **2.5MG & 850MG TABLET**

02389177	KOMBOGLYZE	AZC

SITAGLIPTIN PHOSPHATE MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **25MG TABLET**

02388839	JANUVIA	FRS

ST **50MG TABLET**

02388847	JANUVIA	FRS

ST **100MG TABLET**

02303922	JANUVIA	FRS

SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **50MG & 1000MG TABLET**

02333872	JANUMET	FRS

ST **50MG & 500MG TABLET**

02333856	JANUMET	FRS

ST **50MG & 850MG TABLET**

02333864	JANUMET	FRS

ST **50MG & 1000MG TABLET (EXTENDED RELEASE)**

02416794	JANUMET XR	FRS

ST **50MG & 500MG TABLET (EXTENDED RELEASE)**

02416786	JANUMET XR	FRS

ST **100MG & 1000MG TABLET (EXTENDED RELEASE)**

02416808	JANUMET XR	FRS

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

CANAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **100MG TABLET**

02425483	INVOKANA	JSO

ST **300MG TABLET**

02425491	INVOKANA	JSO

68:20.18 SODIUM-GLUCOSE CONTRANSPORTER 2 (SGLT2) INHIBITORS

DAPAGLIFLOZIN PROPANEDIOL MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **5MG TABLET**

02435462	FORXIGA	AZC

ST **10MG TABLET**

02435470	FORXIGA	AZC

EMPAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **10MG TABLET**

02443937	JARDIANCE	BOE

ST **25MG TABLET**

02443945	JARDIANCE	BOE

METFORMIN HYDROCHLORIDE, DAPAGLIFLOZIN

Limited use benefit (prior approval required).

For the treatment of patients with type 2 diabetes mellitus who did not achieve glycemic control or who demonstrated intolerance to an adequate trial of metformin AND a sulfonylurea.

ST **850MG & 5MG TABLET**

02449935	XIGDUO	AZC

ST **1000MG & 5MG TABLET**

02449943	XIGDUO	AZC

68:20.28 THIAZOLIDINEDIONES

PIOGLITAZONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

ST **15MG TABLET**

02303442	ACCEL PIOGLITAZONE	ACP
02391600	ACH-PIOGLITAZONE	ACC
02302861	ACT PIOGLITAZONE	ACG
02242572	ACTOS	TAK
02302942	APO-PIOGLITAZONE	APX
02307634	DOM-PIOGLITAZONE	DPC
02397307	JAMP-PIOGLITAZONE	JMP
02326477	MINT-PIOGLITAZONE	MIN
02298279	MYLAN-PIOGLITAZONE	MYL
02303124	PMS-PIOGLITAZONE	PMS
02312050	PRO-PIOGLITAZONE	PDL
02375850	RAN-PIOGLITAZONE	RBY
02297906	SANDOZ PIOGLITAZONE	SDZ
02274914	TEVA-PIOGLITAZONE	TEV
02434121	VAN-PIOGLITAZONE	VAN

ST **30MG TABLET**

02303450	ACCEL PIOGLITAZONE	ACP
02339587	ACH-PIOGLITAZONE	ACC
02302888	ACT PIOGLITAZONE	ACG
02242573	ACTOS	TAK

68:20.28 THIAZOLIDINEDIONES

PIOGLITAZONE HYDROCHLORIDE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

ST **30MG TABLET**

02302950	APO-PIOGLITAZONE	APX
02307642	DOM-PIOGLITAZONE	DPC
02365529	JAMP-PIOGLITAZONE	JMP
02326485	MINT-PIOGLITAZONE	MIN
02298287	MYLAN-PIOGLITAZONE	MYL
02303132	PMS-PIOGLITAZONE	PMS
02312069	PRO-PIOGLITAZONE	PDL
02375869	RAN-PIOGLITAZONE	RBY
02297914	SANDOZ PIOGLITAZONE	SDZ
02274922	TEVA-PIOGLITAZONE	TEV
02434148	VAN-PIOGLITAZONE	VAN

ST **45MG TABLET**

02303469	ACCEL PIOGLITAZONE	ACP
02339595	ACH-PIOGLITAZONE	ACC
02302896	ACT PIOGLITAZONE	ACG
02242574	ACTOS	TAK
02302977	APO-PIOGLITAZONE	APX
02307650	DOM-PIOGLITAZONE	DPC
02365537	JAMP-PIOGLITAZONE	JMP
02326493	MINT-PIOGLITAZONE	MIN
02298295	MYLAN-PIOGLITAZONE	MYL
02303140	PMS-PIOGLITAZONE	PMS
02312077	PRO-PIOGLITAZONE	PDL
02375877	RAN-PIOGLITAZONE	RBY
02297922	SANDOZ PIOGLITAZONE	SDZ
02274930	TEVA-PIOGLITAZONE	TEV
02434156	VAN-PIOGLITAZONE	VAN

ROSIGLITAZONE MALEATE

Limited use benefit (prior approval required).

For treatment of type 2 diabetic patients who are not adequately controlled by or are intolerant to metformin and sulfonylureas or for whom these products are contraindicated.

ST **2MG TABLET**

02403366	APO-ROSIGLITAZONE	APX
02241112	AVANDIA	GSK

ST **4MG TABLET**

02403374	APO-ROSIGLITAZONE	APX
02241113	AVANDIA	GSK

ST **8MG TABLET**

02403382	APO-ROSIGLITAZONE	APX
02241114	AVANDIA	GSK

68:32.00 PROGESTINS

DIENOGEST

Limited use benefit (prior approval required).

For the management of pelvic pain associated with endometriosis.

ST **2MG TABLET**

02374900	VISANNE	BAY

PROGESTERONE

Limited use benefit (prior approval required).

For the treatment of women:
- With postmenopausal symptoms who are intolerant to medroxyprogesterone acetate (MPA); OR
- Who are at risk of preterm birth; OR
- Who are using the medication to prevent miscarriage.

ST **100MG CAPSULE**

02166704	PROMETRIUM	FRS
02439913	TEVA-PROGESTERONE	TEV

84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

IMIQUIMOD

Limited use benefit (prior approval required).

For the treatment of condylomata acuminate (genital warts) in patients who have failed:
- self-applied podophyllotoxin (podofilox 0.5% solution); OR
- provider-applied podophyllum resin (10%-25%).

5% CREAM

02239505	ALDARA P	VAE
02407825	APO-IMIQUIMOD	APX

PIMECROLIMUS

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

1% CREAM

02247238	ELIDEL	VAE

SECUKINUMAB

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 12 weeks at a dose of 300mg at Weeks 0, 1, 2 and 3, followed by 300mg per month starting at Week 4.
- Prescribed by a dermatologist

For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:
- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks; AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 12 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):
- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A ≥ 50% reduction in the Psoriasis Area Severity Index (PASI) score with a ≥ 5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

150MG SOLUTION

02438070	COSENTYX	NVR

84:92.00 MISCELLANEOUS SKIN AND MUCOUS MEMBRANE AGENTS

TACROLIMUS (PROTOPIC)

Limited use benefit (prior approval required).

For patients who have failed topical corticosteroid therapy or have experienced side effects from such treatment.

Note: Contraindicated in children less than 2 years of age.

0.03% OINTMENT

02244149	PROTOPIC	LEO

0.1% OINTMENT

02244148	PROTOPIC	LEO

86:00 SMOOTH MUSCLE RELAXANTS

86:12.00 GENITOURINARY SMOOTH MUSCLE RELAXANTS

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **1MG TABLET**

02423308	MINT-TOLTERODINE	MIN

ST **2MG TABLET**

02423316	MINT-TOLTERODINE	MIN

86:12.04 ANTIMUSCARINICS

DARIFENACIN HYDROBROMIDE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

7.5MG TABLET (EXTENDED RELEASE)

02273217	ENABLEX	MRL

15MG TABLET (EXTENDED RELEASE)

02273225	ENABLEX	MRL

FESOTERODINE FUMARATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **4MG TABLET (EXTENDED RELEASE)**

02380021	TOVIAZ	PFI

ST **8MG TABLET (EXTENDED RELEASE)**

02380048	TOVIAZ	PFI

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **1MG TABLET**

02369680	APO-TOLTERODINE	APX
02239064	DETROL	PFI
02299593	TEVA-TOLTERODINE	TEV

ST **2MG TABLET**

02369699	APO-TOLTERODINE	APX

86:12.04 ANTIMUSCARINICS

TOLTERODINE TARTRATE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **2MG TABLET**

02239065	DETROL	PFI
02299607	TEVA-TOLTERODINE	TEV

TROSPIUM CHLORIDE

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **20MG TABLET**

02275066	TROSEC	SPC

86:12.08 BETA-ADRENERGIC AGONISTS

MIRABEGRON

Limited use benefit (prior approval required).

For the symptomatic relief of overactive bladder in patients:
- with symptoms of urinary frequency, urgency or urge incontinence; AND
- who have failed on or are intolerant to therapy with immediate-release oxybutynin OR solifenacin OR tolterodine ER.

ST **25MG TABLET (EXTENDED RELEASE)**

02402874	MYRBETRIQ	AST

ST **50MG TABLET (EXTENDED RELEASE)**

02402882	MYRBETRIQ	AST

88:00 VITAMINS

88:20.00 VITAMIN E

VITAMIN E

Limited use benefit (prior approval required).

For use in malabsorption

ST **100IU CAPSULE**

00122823	VITAMIN E	JAM

ST **200IU CAPSULE**

00122831	VITAMIN E	JAM

ST **400IU CAPSULE**

00122858	VITAMIN E	JAM

ST **800IU CAPSULE (SOFTGEL)**

00330191	VITAMIN E	JAM

ST **50IU ORAL LIQUID**

00480215	AQUASOL E	NVC

ST **50IU/ML ORAL LIQUID**

02162075	AQUASOL E VITAMIN E	CLC

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PEDIATRIC)

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

ST **DROP**

00762946	ENFAMIL POLYVISOL	MJO

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS (PEDIATRIC)

Limited use benefit (prior approval is not required).

Pediatric multivitamins are benefits for children up to 6 years of age.

ST **450MG & 10MG & 30MG LIQUID**

80008471	JAMP VITAMIN A, D AND C	JMP

ST **2,500IU & 666.67IU & 50MG/ML LIQUID**

00762903	ENFAMIL TRIVISOL	MJO
02229790	PEDIAVIT	EUR

ST **TABLET (CHEWABLE)**

80011134	CENTRUM JUNIOR COMPLETE	PFI
80020794	CENTRUM JUNIOR COMPLETE	PFI
02247995	FLINTSTONES MULTIPLE VITAMINS PLUS IRON	BAY
02247975	FLINTSTONES MULTIPLE VITAMINS WITH EXTRA C	BAY

MULTIVITAMINS (PRENATAL)

Limited use benefit (prior approval is not required.).

Prenatal and postnatal vitamins are benefits only for women of childbearing age (12 to 50 years).

ST **TABLET**

80042704	CENTRUM DHA	PFI
80045822	CENTRUM PRENATAL	PFI
80001842	NESTLÉ MATERNA	NES
02241235	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	VTH
80005770	PRENATAL AND POSTPARTUM VITAMINS AND MINERALS	PMT
02229535	WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID	WAM

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

EXTEMPORANEOUS MIXTURE (LU)

Limited use benefit (prior approval required).

MISCELLANEOUS

99504001	MISC LIMITED USE EXTERNAL COMPOUND MIXTURE	UNK

ORAL LIQUID

99503033	MISC LIMITED USE COMPOUND INTERNAL	UNK
99503032	OPIOID COMPOUNDED	UNK

92:00.00 UNCLASSIFIED THERAPEUTIC AGENTS

USTEKINUMAB

Limited use benefit (prior approval required).

Coverage is provided for an initial period of 16 weeks. For patients ≤ 100 kg, the initial dose is 45 mg at week 0, followed by 45 mg at weeks 4 and 16. Alternatively, ustekinumab 90 mg may be used in patients weighing more than 100 kg. Response must be assessed prior to a fourth dose and further doses will be provided only for responders.

- Prescribed by a dermatologist

For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks; AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):

- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A ≥ 50% reduction in the Psoriasis Area Severity Index (PASI) score with a ≥ 5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

45MG/0.5ML SOLUTION

02320673	STELARA	JSO

90MG/ML SOLUTION

02320681	STELARA	JSO

92:08.00 5 ALFA REDUCTASE INHIBITORS

DUTASTERIDE

Limited use benefit (prior approval required).

For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an adrenergic blocker.
OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

ST **0.5MG CAPSULE**

02412691	ACT DUTASTERIDE	ACG
02404206	APO-DUTASTERIDE	APX
02247813	AVODART	GSK
02421712	DUTASTERIDE	PDL
02429012	DUTASTERIDE	SIV
02443058	DUTASTERIDE	SAN
02416298	MED-DUTASTERIDE	GMP
02428873	MINT-DUTASTERIDE	MIN
02393220	PMS-DUTASTERIDE	PMS
02427753	RIVA-DUTASTERIDE	RIV
02424444	SANDOZ DUTASTERIDE	SDZ
02408287	TEVA-DUTASTERIDE	TEV

FINASTERIDE

Limited use benefit (prior approval required).

For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an alpha-adrenergic blocker.
OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

ST **5MG TABLET**

02355043	ACH-FINASTERIDE	ACC
02354462	ACT FINASTERIDE	ACG
02365383	APO-FINASTERIDE	APX
02405814	AURO-FINASTERIDE	AUR
02376709	DOM-FINASTERIDE	DPC
02350270	FINASTERIDE	PDL
02445077	FINASTERIDE	SAN

92:08.00 5 ALFA REDUCTASE INHIBITORS

FINASTERIDE

Limited use benefit (prior approval required).

For treatment of Benign Prostatic Hyperplasia (BPH) in patients who do not tolerate or have not responded to an alpha-adrenergic blocker.
OR
For use in combination therapy when monotherapy with an alpha-blocker is not sufficient.

5MG TABLET

02447541	FINASTERIDE	SIV
02357224	JAMP-FINASTERIDE	JMP
02389878	MINT-FINASTERIDE	MIN
02310112	PMS-FINASTERIDE	PMS
02010909	PROSCAR	FRS
02371820	RAN-FINASTERIDE	RBY
02306905	RATIO-FINASTERIDE	TEV
02455013	RIVA-FINASTERIDE	RIV
02322579	SANDOZ FINASTERIDE	SDZ
02348500	TEVA-FINASTERIDE	TEV
02428741	VAN-FINASTERIDE	VAN

92:16.00 ANTIGOUT AGENTS

FEBUXOSTAT

Limited use benefit (prior approval required).

For patients with symptomatic gout who have documented hypersensitivity to allopurinol.

80MG TABLET

02357380	ULORIC	TAK

92:24.00 BONE RESORPTION INHIBITORS

DENOSUMAB (PROLIA)

Limited use benefit (prior approval required).

For women with postmenopausal osteoporosis who have failed or have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);

AND who have at least two of the following:
- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score ≤ -2.5

Maximum dose covered is 60mg per 6-month period.

60MG/ML SOLUTION

02343541	PROLIA	AMG

DENOSUMAB (XGEVA)

Limited use benefit (prior approval required).

For the prevention of skeletal-related events (SREs) in patients with castrate-resistant prostate cancer (CRPC) with:
- one or more documented bone metastases; AND
- good performance status (ECOG performance status score of 0, 1, or 2).

120MG/1.7ML SOLUTION

02368153	XGEVA	AMG

92:24.00 BONE RESORPTION INHIBITORS

ZOLEDRONIC ACID MONOHYDRATE

Limited use benefit (prior approval required).

For the treatment of Paget's disease. Coverage will be granted for one dose per 12 month period;
OR
For women with postmenopausal osteoporosis who would otherwise be eligible for coverage of oral bisphosphonates, but who have a contraindication to bisphosphonates due to hypersensitivity or abnormalities of the esophagus (e.g., esophageal stricture or achalasia);
AND who have at least two of the following:

- age >70 years
- a prior fragility fracture
- a bone mineral density (BMD) T-score ≤ - 2.5.

5MG/100ML SOLUTION

02269198	ACLASTA	NVR
02415100	TARO-ZOLEDRONIC ACID	TAR
02408082	ZOLEDRONIC ACID	TEV
02422433	ZOLEDRONIC ACID	REC

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ABATACEPT

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 500mg IV for patients weighting <60kg; 750mg IV for patients weighting 60kg to 100kg; and 1000mg IV for patients weighing >100kg. Initial IV doses are given at 0, 2, and 4 weeks, then every 4 weeks. Alternatively, a single weight-based IV loading dose is covered (if required), followed by 125mg SC weekly.

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:

- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:

- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

AND (FOR IV FORMULATION ONLY):

- etanercept (sc) OR adalimumab (sc) OR golimumab (sc) OR certolizumab (sc) OR abatacept (sc) OR tocilizumab OR tofacitinib (po) or Inflectra (iv): for a minimum trial of 12 weeks.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.

- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for an initial period of 16 weeks at a dose of 10mg/kg for children weighing < 75kg; Pediatric patients weighing 75kg or more should be dosed according to the adult regimen, not to exceed a maximum dose of 1000mg. Doses are given at 0, 2, and 4 weeks, then every 4 weeks.

- Prescribed by a rheumatologist

In patients six to seventeen years of age who meet the following criteria:

- ≥ 5 swollen joints; AND
- ≥ 3 joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters
Patient has experienced 3 of 6 of the following variables:

- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

250MG POWDER FOR SOLUTION

02282097	ORENCIA	BMS

125MG SOLUTION

02402475	ORENCIA	BMS

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ADALIMUMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.
- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:
- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:
- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:
- methotrexate weekly (weekly oral or parenteral)at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).
- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 40 mg every two weeks.
- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) (weekly oral or parenteral) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.
- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

Coverage is provided for an initial period of 16 weeks at a dose of 80 mg as an initial dose, followed by 40 mg every 2 weeks, starting one week after the initial dose.
- Prescribed by a dermatologist
- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region; AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy; AND
- Intolerance or lack of response to methotrexate (MTX) (weekly oral or parenteral)at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more

than 8 weeks; AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

Coverage beyond 16 weeks will be based on a significant reduction in the Body Surface Area (BSA) involved and improvements in the Psoriasis Area Severity Index (PASI) score and the Dermatology Life Quality Index (DLQI):
- A 75% reduction in Psoriasis Area Severity Index (PASI) score; OR
- A ≥ 50% reduction in the Psoriasis Area Severity Index (PASI) score with a ≥ 5-point improvement in the Dermatology Life Quality Index (DLQI); OR
- A significant reduction in Body Surface Area (BSA) involved, with consideration of important areas such as the face, hands, feet or genital regions.

5. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial period of 12 weeks at an induction dose of 160 mg, followed by 80 mg two weeks later. Maintenance therapy is provided at a dose not exceeding 40 mg every two weeks.
- Prescribed by a gastroenterology specialist

Patient meets the following criteria:
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks..

Coverage beyond the initial twelve-week period will be based on improvement in the CDAI or HBI scores.
- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

6. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 24 mg/m2 body surface area up to a maximum single dose of 40 mg every other week.
- Prescribed by a rheumatologist

In patients two years of age and older who meet the following criteria:
- ≥ 5 swollen joints; AND
- ≥ 3 joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond the initial one-year period will be based on a 30% improvement in 3 of 6 clinical parameters
Patient has experienced 3 of 6 of the following variables:
- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of 12 weeks at a dose of 160 mg at week 0, followed by 80 mg two weeks later and then 40 mg every two weeks thereafter.
- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:
- 5-ASA 4grams/day for 6 weeks; PLUS
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or cont[illegible]ication.

Coverage beyond the initial 12 week period will be based on improvement in the partial Mayo score of ≥ 2 points.

40MG/VIAL SOLUTION

02258595	HUMIRA	ABV

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

CERTOLIZUMAB PEGOL

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.
- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:
- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:
- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:
- methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).
- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 400mg at weeks 0, 2, and 4, followed by 200mg every other week or 400mg every 4 weeks.
- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond the initial three doses will be based on improvement in the BASDAI score.
- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

200MG SOLUTION

02465574 CIMZIA UCB

200MG/ML SOLUTION

02331675 CIMZIA UCB

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

ETANERCEPT

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.
- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:
- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:
- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:
- methotrexate (oral or parenteral) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).
- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 50 mg weekly.
- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly (oral or parenteral) at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.
- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Coverage is provided for children age 4 to 17, for an initial period of one year at a dose of 0.8 mg/kg/week body surface area up to a maximum single dose of 50 mg/week.
- Prescribed by a rheumatologist

In patients four to seventeen years of age and older who meet the following criteria:
- ≥ 5 swollen joints; AND
- ≥ 3 joints with limited range of motion and/or pain/tenderness; AND

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- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond the initial one-year period will be based on a 30% improvement in 3 of 6 clinical parameters.
Patient has experienced 3 of 6 of the following variables:
- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR

AND
- No more than one of these variables has worsened by greater than 30%

25MG/VIAL INJECTION

02242903	ENBREL	PED

50MG/ML INJECTION

02274728	ENBREL	PED
99100373	ENBREL SURECLICK	AMG

ETANERCEPT (BRENZYS)

Limited use benefit (prior approval required).

Coverage for BRENZYS will be approved indefinitely.

1. For the treatment of severely active RHEUMATOID ARTHRITIS

- Prescribed by a rheumatologist.

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

2. For the treatment of ANKYLOSING SPONDYLITIS

- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly (oral or parenteral) at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

50MG SOLUTION

02455323	BRENZYS	UNK
02455331	BRENZYS	UNK

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

GOLIMUMAB

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond one year will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.
- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:
- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:
- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:
- methotrexate weekly parenteral at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

Coverage beyond one year will be based on improvement according to the Psoriatic Arthritis Response Criteria (PsARC).
- Improvement in at least two of the four PsARC criteria, one of which has to be joint tenderness or swelling score, with no worsening in any of the four criteria. A response in joint count is determined by a reduction of ≥ 30%. A response in the Physician or Patient Global Assessment scale is determined by a reduction of 1 point.

3. For the treatment of ANKYLOSING SPONDYLITIS

Coverage is provided for an initial period of one year at a dose of 50 mg every month.
- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) (oral or parenteral) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

Coverage beyond one year will be based on improvement in the BASDAI score.
- Improvement of at least 50% or 2 units in the Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) score.

4. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of three months at a dose of 200 mg at week 0, followed by 100 mg at week 2 and then 50 mg every four weeks thereafter.
- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:

- 5-ASA 4grams/day for 6 weeks; PLUS

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- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

The treating physician may utilize 100 mg every four weeks as a maintenance dose if necessary.

Coverage beyond one year will be based on a decrease in the partial Mayo score of ≥ 2 points and patients should be off corticosteroids.

50MG/0.5ML SOLUTION

02324776	SIMPONI	JSO
02324784	SIMPONI	JSO

100MG/ML SOLUTION

02413175	SIMPONI	JSO
02413183	SIMPONI	JSO

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INFLIXIMAB (INFLECTRA)

Limited use benefit (prior approval required).

Coverage for INFLECTRA will be approved indefinitely.

1. For the treatment of severely active RHEUMATOID ARTHRITIS

- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

2. For the treatment of moderate to severe PSORIATIC ARTHRITIS

- Prescribed by a rheumatologist

Client who meet at least 2 of the following criteria:
- 5 or more swollen joints
- if less than 5 swollen joints, at least one joint proximal to, or including wrist or ankle
- more than one joint with erosion on imaging study
- dactylitis of two or more digits
- tenosynovitis refractory to oral NSAIDs and steroid injections
- enthesitis refractory to oral NSAIDs and steroid injections (not required for Achilles tendon)
- inflammatory spinal symptoms refractory to two NSAIDs (minimum four weeks trial each) and has a BASDAI greater than 4
- daily use of corticosteroids
- use of opioids > 12 hours per day for pain resulting from inflammation

AND patient is refractory to:
- a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks;

PLUS a minimum of any two of the following:
- methotrexate weekly parenteral (SC or IM) at 20mg or greater (15mg or greater if patient is >65 years of age) for more than 8 weeks; OR
- leflunomide: 20mg daily for 10 weeks; OR
- sulfasalazine at least 2g daily for 3 months; OR
- cyclosporine

OR Axial disease with both of the following:
- Bath Ankylosing Spondylitis Disease Activity Index (BASDAI) ≥ 4; AND
- Patient is refractory to a trial of at least two different NSAIDs at maximum tolerated doses for a combined total duration of four weeks.

3. For the treatment of ANKYLOSING SPONDYLITIS

- Prescribed by a rheumatologist
- BASDAI > 4; AND
- Patient is refractory to a trial of two different NSAIDs at maximum tolerated doses for a combined total duration of at least 4 weeks;

AND for peripheral joint involvement, patient is refractory:
- Methotrexate (MTX) weekly at 20 mg or greater (15 mg or greater if patient is >65 years of age) for more than 8 weeks; AND
- Sulfasalazine 2 g/day for at least 3 months.

NOTE: For axial involvement, patient does not need to be tried on methotrexate or sulfasalazine.

4. For the treatment of patients with moderate to severe PSORIASIS who meet all of the following criteria:

- Prescribed by a dermatologist
- Body surface area (BSA) involvement greater than 10% and/or significant involvement of the face, hands, feet or genital region;

AND
- Intolerance or lack of response to phototherapy; OR
- Inability to access phototherapy;

AND
- Intolerance or lack of response to methotrexate (MTX) weekly oral or parenteral (SC or IM) at 20 mg or greater (15 mg or greater if patient is > 65 years of age) for more than 8 weeks;

AND
- Intolerance or lack of response to cyclosporine; OR
- A contraindication to methotrexate or cyclosporine.

5. For the treatment of moderately to severely active CROHN`S DISEASE

- Prescribed by a gastroenterology specialist

Patient meets the following criteria:
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

6. For the treatment of FISTULIZING CROHN"S DISEASE

- Prescribed by a gastroenterology specialist

Patient meets all the following criteria:
- Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);

PLUS
Patient has failed a trial of one (1) immunosuppressive agent:
- Azathioprine 2 to 2.5 mg/kg/day for a minimum of 3 months or treatment discontinued at < 3 months due to severe adverse: reactions.

OR
- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at <3 months due to severe adverse reactions.

7. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:
- 5-ASA 4grams/day for 6 weeks; PLUS
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

100MG POWDER FOR SOLUTION

02419475	INFLECTRA	HOS

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

INFLIXIMAB (REMICADE)

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial three doses of 3 mg/kg, administered at 0, 2 and 6 weeks.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX; AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of moderately to severely active CROHN`S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.
- Prescribed by a gastroenterology specialist

Patient meets the following criteria:
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

Coverage beyond the initial three doses will be based on improvement in the CDAI or HBI scores.
- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

3. For the treatment of FISTULIZING CROHN"S DISEASE

Coverage is provided for an initial three doses of 5 mg/kg, administered at 0, 2 and 6 weeks.
- Prescribed by a gastroenterology specialist

Patient meets all the following criteria:
- Patients with actively draining perianal or enterocutaneous fistulae that are refractory to a course of appropriate antibiotic therapy (e.g. ciprofloxacin with or without metronidazole for a minimum of 3 weeks);

PLUS

Patient has failed a trial of one (1) immunosuppressive agent:
- Azathioprine 2 to 2.5 mg/kg/day for a minimum of 3 months or treatment discontinued at < 3 months due to severe adverse: reactions. OR
- 6-mercaptopurine 50-70 mg/day for a minimum of 3 months or treatment discontinued at <3 months due to severe adverse reactions.

Coverage beyond the initial three doses will be based on improvement or closure of actively draining fistulae
- Closure of individual fistulae as evidenced by no, or minimal, fistulae drainage and bleeding.

100MG/VIAL POWDER FOR SOLUTION

02244016 REMICADE JSO

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

TOCILIZUMAB (IV)

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for 16 weeks at an initial dose of 4 mg/kg/dose every 4 weeks.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond 16 weeks, at a dose of up to 8 mg/kg/dose (maximum dose of 800 mg per infusion) every 4 weeks, is based on a 20% improvement from baseline in swollen and tender joint counts, plus a 20% improvement in 2 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

2. For the treatment of active SYSTEMIC JUVENILE IDIOPATHIC ARTHRITIS

Initial 16-week coverage is provided at a dose of 12 mg/kg once every two weeks for children weighing < 30 kg and 8 mg/kg for children weighing ≥ 30 kg.
- Prescribed by a rheumatologist

In patients two to seventeen years of age and older who meet the following criteria:
- Have responded inadequately to non-steroidal anti-inflammatory drugs (NSAIDs) and systemic corticosteroids (with or without methotrexate), due to intolerance or lack of efficacy.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters
Patient has experienced 3 of 6 of the following variables:
- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR

AND
- No more than one of these variables has worsened by greater than 30%

3. For the treatment of severely active polyarticular JUVENILE IDIOPATHIC ARTHRITIS

Initial 16-week coverage is provided at a dose of 10 mg/kg once every four weeks for children weighing < 30 kg and 8 mg/kg for children weighing ≥ 30 kg.
- Prescribed by a rheumatologist

In patients two years of age and older who meet the following criteria:
- ≥ 5 swollen joints; AND
- ≥ 3 joints with limited range of motion and/or pain/tenderness; AND
- Condition is refractory to an adequate trial of a therapeutic dose of methotrexate.

Coverage beyond 16 weeks is based on a >30% improvement in 3 of 6 baseline clinical parameters
Patient has experienced 3 of 6 of the following variables:
- >30% reduction in the number of active joints
- >30% reduction in the number of joints with loss of range of motion
- >30% improvement in the Physician Global Assessment scale
- >30% improvement in the Patient or Parent Global Assessment scale
- >30% improvement in the Child Health Assessment Questionnaire (CHAQ)
- >30% reduction in ESR; AND
- No more than one of these variables has worsened by greater than 30%

80MG/4ML SOLUTION

02350092 ACTEMRA HLR

200MG/10ML SOLUTION

02350106 ACTEMRA HLR

400MG/20ML SOLUTION

02350114 ACTEMRA HLR

92:36.00 DISEASE-MODIFYING ANTIRHEUMATIC AGENTS

TOCILIZUMAB (SC)

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage is provided for an initial period of one year. Initial approvals for patients < 100 kg will be for a dose of 162 mg every other week up to a maximum dose of 162 mg every week (Maximum 51 doses). For patients weighing 100 kg or more, coverage is provided at a dose of 162 mg weekly (Maximum 52 doses).
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

162MG SOLUTION

02424770	ACTEMRA	HLR

TOFACITINIB CITRATE

Limited use benefit (prior approval required).

1. For the treatment of severely active RHEUMATOID ARTHRITIS

Coverage of tofacitinib in adult patients ≥ 18 years is provided at a MAXIMUM dose of 10mg daily for an initial period of one year.
- Prescribed by a rheumatologist

Coverage is provided, in combination with methotrexate (MTX) or other disease modifying anti-rheumatic drugs (DMARDs), for the reduction in signs and symptoms of severely active RA in adult patients ≥ 18 years who have failed:
- MTX (oral or parenteral) at a dose ≥ 20 mg weekly (≥ 15 mg weekly if patient is ≥ 65 years) for a minimum of 12 weeks of continuous treatment. Note: Patients who do not exhibit a clinical response to oral MTX or who experience gastrointestinal intolerance may consider a trial of parenteral MTX;

AND
- MTX in combination with at least two other DMARDS, such as sulfasalazine and hydroxychloroquine, for a minimum of 12 weeks of continuous treatment;

OR, if the patient has a contraindication, failure, or intolerance to MTX:
- A combination of at least two DMARDS, such as sulfasalazine, hydroxychloroquine, azathioprine, leflunomide, cyclosporine or gold, for a minimum of 12 weeks of continuous treatment.

Coverage beyond the initial three doses will be based on a 20% improvement in 3 of 5 baseline clinical parameters.
- >20% reduction in number of tender and swollen joints; PLUS
- >20% improvement in Physician Global Assessment scale; PLUS either
- >20% improvement in Patient Global Assessment scale; OR
- >20% reduction in the acute phase as measured by ESR or CRP.

5MG TABLET

02423898	XELJANZ	PFI

92:44.00 IMMUNOSUPPRESSIVE AGENTS

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

ST **10MG CAPSULE**

02237671	NEORAL	NVR

ST **25MG CAPSULE**

02150689	NEORAL	NVR
02247073	SANDOZ CYCLOSPORINE	SDZ

ST **50MG CAPSULE**

02150662	NEORAL	NVR
02247074	SANDOZ CYCLOSPORINE	SDZ

92:44.00 IMMUNOSUPPRESSIVE AGENTS

CYCLOSPORINE

Limited use benefit (prior approval required).

For transplant therapy.

100MG CAPSULE

02150670	NEORAL	NVR
02242821	SANDOZ CYCLOSPORINE	SDZ

100MG/ML SOLUTION

02244324	APO-CYCLOSPORINE	APX
02150697	NEORAL	NVR

MYCOPHENOLATE MOFETIL

Limited use benefit (prior approval required).

For transplant therapy.

250MG CAPSULE

02383780	ACH-MYCOPHENOLATE	ACC
02352559	APO-MYCOPHENOLATE	APX
02192748	CELLCEPT	HLR
02386399	JAMP-MYCOPHENOLATE	JMP
02457369	MYCOPHENOLATE MOFETIL	SAN
02371154	MYLAN-MYCOPHENOLATE	MYL
02320630	SANDOZ MYCOPHENOLATE	SDZ
02364883	TEVA-MYCOPHENOLATE	TEV
02433680	VAN-MYCOPHENOLATE	VAN

500MG TABLET

02352567	APO-MYCOPHENOLATE	APX
02237484	CELLCEPT	HLR
02380382	JAMP-MYCOPHENOLATE	JMP
02378574	MYCOPHENOLATE	ACC
02457377	MYCOPHENOLATE MOFETIL	SAN
02370549	MYLAN-MYCOPHENOLATE	MYL
02313855	SANDOZ MYCOPHENOLATE	SDZ
02348675	TEVA-MYCOPHENOLATE	TEV
02432625	VAN-MYCOPHENOLATE	VAN

MYCOPHENOLATE SODIUM

Limited use benefit (prior approval required).

For transplant therapy.

180MG TABLET (ENTERIC COATED)

02372738	APO-MYCOPHENOLIC ACID	APX
02264560	MYFORTIC	NVR

360MG TABLET (ENTERIC COATED)

02372746	APO-MYCOPHENOLIC ACID	APX
02264579	MYFORTIC	NVR

SIROLIMUS

Limited use benefit (prior approval required).

Coverage will be provided as a second line therapy for patients failing mycophenolate mofetil.

1MG/ML SOLUTION

02243237	RAPAMUNE	PFI

1MG TABLET

02247111	RAPAMUNE	PFI

92:44.00 IMMUNOSUPPRESSIVE AGENTS

TACROLIMUS MONOHYDRATE

Limited use benefit (prior approval required).

For transplant therapy.

0.5MG CAPSULE

02243144	PROGRAF	AST
02416816	SANDOZ TACROLIMUS	SDZ

1MG CAPSULE

02175991	PROGRAF	AST
02416824	SANDOZ TACROLIMUS	SDZ

5MG CAPSULE

02175983	PROGRAF	AST

0.5MG CAPSULE (EXTENDED RELEASE)

02296462	ADVAGRAF	AST

1MG CAPSULE (EXTENDED RELEASE)

02296470	ADVAGRAF	AST

3MG CAPSULE (EXTENDED RELEASE)

02331667	ADVAGRAF	AST

5MG CAPSULE (EXTENDED RELEASE)

02296489	ADVAGRAF	AST

5MG CAPSULE (IMMEDIATE RELEASE)

02416832	SANDOZ TACROLIMUS	SDZ

5MG/ML SOLUTION

02176009	PROGRAF	AST

VEDOLIZUMAB

Limited use benefit (prior approval required).

1. For the treatment of moderately to severely active CROHN'S DISEASE

Coverage is provided for an initial period of 14 weeks at a dose of 300 mg weeks zero, two and six and then every eight weeks. Maintenance therapy is provided at a dose not exceeding 300 mg every eight weeks.
- Prescribed by a gastroenterology specialist

Patient meets the following criteria:
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication;

PLUS
- Azathioprine 2 mg/kg/day for a minimum of 12 weeks; OR
- 6-mercaptopurine 1 mg/day for a minimum of 12 weeks; OR
- MTX (oral or parenteral) 15 mg per week for a minimum of 12 weeks.

Coverage beyond the initial 14 week period will be based on improvement in the CDAI or HBI scores.
- At least a 100-point reduction in the Crohn's Disease Activity Index (CDAI) OR at least a 3-point reduction in the Harvey Bradshaw Index (HBI).

2. For the treatment of adult patients with moderately to severely active ULCERATIVE COLITIS who meet the following:

Coverage is provided for an initial period of 14 weeks at a dose of 300 mg at weeks zero, two and six and then every eight weeks. Maintenance therapy is provided at a dose not exceeding 300 mg every eight weeks.
- Prescribed by expert in gastroenterology
- Partial Mayo score > 4
- Inadequate response to conventional therapies:
- 5-ASA 4grams/day for 6 weeks; PLUS
- Glucocorticoids equivalent to prednisone 40 mg/day for a minimum of 2 weeks OR treatment discontinued due to intolerance or contraindication.

Coverage beyond the initial 14 week period will be based on improvement in the partial Mayo score of ≥ 2 points.

300MG POWDER FOR SOLUTION

02436841	ENTYVIO	TAK

92:92.00 OTHER MISCELLANEOUS THERAPEUTIC AGENTS

INCOBOTULINUMTOXINA

Limited use benefit (prior approval required).

For the treatment of:
- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis).

50UNIT/VIAL POWDER FOR SOLUTION

02371081	XEOMIN	MEZ

100U/VIAL POWDER FOR SOLUTION

02324032	XEOMIN	MEZ

ONABOTULINUMTOXINA

Limited use benefit (prior approval required).

For the treatment of:
- strabismus and blepharospasm associated with dystonia, including benign essential blepharospasm or VII nerve disorder in patients 12 years of age or older; OR
- cervical dystonia (spasmodic torticollis); OR
- urinary incontinence due to neurogenic detrusor over activity resulting from neurogenic bladder associated with MS or subcervical spinal cord injury.

50IU INJECTION

09857386	BOTOX	ALL

200IU INJECTION

09857387	BOTOX	ALL

100IU POWDER FOR SOLUTION

01981501	BOTOX	ALL

94:00 DEVICES

94:00.00 DEVICES

SPACER DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

DEVICE

96899962	AEROCHAMBER AC BOYZ	TRU
96899963	AEROCHAMBER AC GIRLZ	TRU
96899969	AEROCHAMBER PLUS FLOWVU LARGE	TRU
96899970	AEROCHAMBER PLUS FLOWVU MEDIUM	TRU
96899968	AEROCHAMBER PLUS FLOWVU MOUTH	TRU
96899971	AEROCHAMBER PLUS FLOWVU SMALL	TRU
96899977	AEROTRACH PLUS	UNK
96899956	COMPACT SPACE PLUS LARGE MASK	MIN
96899955	COMPACT SPACE PLUS MEDIUM MASK	MIN
96899953	COMPACT SPACE PLUS NO MASK	MIN
96899954	COMPACT SPACE PLUS SMALL MASK	MIN
99400507	E-Z SPACER	WEP
99400511	E-Z SPACER (MASK ONLY)	WEP
99400508	E-Z SPACER WITH SMALL MASK	WEP
99400501	OPTICHAMBER	AUC
96899961	OPTICHAMBER DIAMOND (CHAMBER)	AUC
96899958	OPTICHAMBER DIAMOND LARGE MASK	AUC
96899959	OPTICHAMBER DIAMOND MEDIUM MASK	AUC
96899960	OPTICHAMBER DIAMOND SMALL MASK	AUC
99400504	OPTICHAMBER LARGE MASK	AUC
99400503	OPTICHAMBER MEDIUM MASK	AUC
99400502	OPTICHAMBER SMALL MASK	AUC

94:00.00 DEVICES

SPACER DEVICE

Limited use benefit with quantity and frequency limits (prior approval is not required).

Coverage is granted for 2 spacer devices every 12 months.

DEVICE

99400505	OPTIHALER	AUC
99400787	POCKET CHAMBER	MCA
99400791	POCKET CHAMBER WITH ADULT MASK	MCA
99400788	POCKET CHAMBER WITH INFANT MASK	MCA
99400790	POCKET CHAMBER WITH MEDIUM MASK	MCA
99400789	POCKET CHAMBER WITH SMALL MASK	MCA
96899974	RESPICHAMBER SILICONE MEDIUM MASK	TRU
96899973	RESPICHAMBER SILICONE SMALL MASK	TRU
96899972	RESPICHAMBER VHC W MOUTHPIECE	TRU

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

DEVICE

97799674	CARTRIDGE FOR IR200	UNK
97799342	INSET 30 INFUSION SETS	UNK
99401038	INSULIN PUMP BATTERY	AUC
09991458	IV3000	SMW

COMFORT ANGLED DEVICE

97799682	COMFORT ANGLED INFSET 17MM	UNK
97799683	COMFORT ANGLED INFSET 17MM	UNK

COMFORT SHORT ANGLED DEVICE

97799678	COMFORT SRT ANGLED INFSET 13	UNK
97799679	COMFORT SRT ANGLED INFSET 13	UNK

CONTACT DETACH DEVICE

97799672	CONTACT DETACH 90 DEGREE 6MMX60CM	UNK
97799610	CONTACT DETACH 90 DEGREE 8MMX60CM	UNK

INSET II DEVICE

97799685	INSET II 90 DEGREE 6MMX110CM	UNK
97799687	INSET II 90 DEGREE 6MMX60CM	UNK
97799684	INSET II 90 DEGREE 9MMX110CM	UNK
97799686	INSET II 90 DEGREE 9MMX60CM	UNK

MIO DEVICE

97799491	MIO BLUE 6MMX18	MDT
97799438	MIO BLUE 6MMX23	MDT
97799490	MIO CLEAR 6MMX32	MDT
97799489	MIO CLEAR 9MMX32	MDT
97799492	MIO PINK 6MMX18	MDT
97799437	MIO PINK 6MMX23	MDT

OMNIPOD DEVICE

09991327	PODS	UNK

PARADIGM SILHOUETTE DEVICE

97799715	PARADIGM SILHOUETTE 13MMX 43	MDT
97799485	PARADIGM SILHOUETTE 13MMX18"	MDT
97799716	PARADIGM SILHOUETTE 13MMX23	MDT

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

PARADIGM SILHOUETTE DEVICE

97799484	PARADIGM SILHOUETTE 13MMX32"	MDT
97799718	PARADIGM SILHOUETTE 17MMX23	MDT
97799483	PARADIGM SILHOUETTE 17MMX32"	MDT
97799719	PARADIGM SILHOUETTE 17MMX43	MDT
97799529	PARADIGM SILHOUETTE CANNULA 13MM	MDT
97799528	PARADIGM SILHOUETTE CANNULA 17MM	MDT

QUICK-SET DEVICE

97799486	QUICK-SET 6MMX18	MDT
97799744	QUICK-SET 6MMX23 TUBING	MDT
97799487	QUICK-SET 6MMX32	MDT
97799743	QUICK-SET 6MMX43 TUBING	MDT
97799742	QUICK-SET 9MMX23 TUBING	MDT
97799488	QUICK-SET 9MMX32	MDT
97799741	QUICK-SET 9MMX43 TUBING	MDT

RAPID-D DEVICE

97799650	RAPID-D 10MM/110CM	ROD
97799652	RAPID-D 10MM/60CM	ROD
97799651	RAPID-D 10MM/80CM	ROD
97799656	RAPID-D 6MM/110CM	ROD
97799658	RAPID-D 6MM/60CM	ROD
97799657	RAPID-D 6MM/80CM	ROD
97799653	RAPID-D 8MM/110CM	ROD
97799655	RAPID-D 8MM/60CM	ROD
97799654	RAPID-D 8MM/80CM	ROD

SURE-T DEVICE

97799521	PARADIGM SURE-T 29G 6MMX18	MDT
97799520	PARADIGM SURE-T 29G 6MMX23	MDT
97799519	PARADIGM SURE-T 29G 8MMX23	MDT

TENDER DEVICE

97799644	TENDER-1 17MM/110CM	ROD
97799646	TENDER-1 17MM/60CM	ROD
97799645	TENDER-1 17MM/80CM	ROD
97799638	TENDER-2 17MM/110CM	ROD
97799640	TENDER-2 17MM/60CM	ROD
97799639	TENDER-2 17MM/80CM	ROD

TENDER "MINI" DEVICE

97799647	TENDER-1 MINI INF SET 13MM/110CM	ROD
97799649	TENDER-1 MINI INFSET 13MM/60CM	ROD
97799648	TENDER-1 MINI INFSET 13MM/80CM	ROD
97799641	TENDER-2 MINI INF SET 13MM/110CM	ROD
97799643	TENDER-2 MINI INFSET 13MM/60CM	ROD
97799642	TENDER-2 MINI INFSET 13MM/80CM	ROD

ULTRAFLEX DEVICE

97799665	ULTRAFLEX 1 10MM/110CM	ROD
97799667	ULTRAFLEX 1 10MM/60CM	ROD
97799666	ULTRAFLEX 1 10MM/80CM	ROD
97799668	ULTRAFLEX 1 8MM/110CM	ROD

94:01.00 DEVICES (DIABETIC)

INSULIN PUMP SUPPLIES

Limited use benefit (prior approval required).

- Insulin pump supplies are approved for NIHB clients following the approval of an insulin pump by NIHB; OR
- Insulin pump supplies are approved for NIHB clients with Type 1 diabetes if an insulin pump was partially or totally covered by another insurance.

ULTRAFLEX DEVICE

97799670	ULTRAFLEX 1 8MM/60CM	ROD
97799669	ULTRAFLEX 1 8MM/80CM	ROD

SYRINGE

97799707	RESERVOIR PARADIGM 5X1.8ML	MDT
97799706	RESERVOIR PARADIGM 7X3.0ML	MDT

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

VANCOMYCIN HYDROCHLORIDE (INJECTION)

Limited use benefit (prior approval required).

POWDER

99100176	VANCOMYCIN	MDS

AA-TRIMEBUTINE 18
ABATACEPT 81
ABENOL 36
ABILIFY 43
ABIRATERONE ACETATE 8
ACAMPROSATE CALCIUM 54
ACCEL PIOGLITAZONE 73
ACCEL-DONEPEZIL 15
ACCOLATE 61
ACCU-CHEK ADVANTAGE 56
ACCU-CHEK AVIVA 56
ACCU-CHEK COMPACT 56
ACCU-CHEK MOBILE BG 56
ACCU-CHEK MOBILE CASSETT 56
ACCUTREND 56
ACET 325 36
ACET 650 36
ACET CODEINE 30 28
ACETAMINOPHEN 35
ACETAMINOPHEN 35
ACETAMINOPHEN, CAFFEINE CITRATE, CODEINE PHOSPHATE 28
ACETAMINOPHEN, CODEINE PHOSPHATE 28
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RAN-OMEPRAZOLE 67
RAN-PANTOPRAZOLE 69
RAN-PIOGLITAZONE 73
RAN-PREGABALIN 41
RAN-RABEPRAZOLE 69
RAPAMUNE 94
RAPID-D 10MM/110CM 98
RAPID-D 10MM/60CM 98
RAPID-D 10MM/80CM 98
RAPID-D 6MM/110CM 98
RAPID-D 6MM/60CM 98
RAPID-D 6MM/80CM 98
RAPID-D 8MM/110CM 98
RAPID-D 8MM/60CM 98
RAPID-D 8MM/80CM 98
RATIO-BUPROPION 43
RATIO-FINASTERIDE 80
RATIO-LENOLTEC NO 2 28
RATIO-LENOLTEC NO 3 28
RATIO-MORPHINE 32
RATIO-OMEPRAZOLE 67
RATIO-RIVASTIGMINE 17
REMICADE 91
RENAGEL 58
RESERVOIR PARADIGM 5X1.8ML 99
RESERVOIR PARADIGM 7X3.0ML 99
RESPICHAMBER SILICONE MEDIUM MASK 97
RESPICHAMBER SILICONE SMALL MASK 97
RESPICHAMBER VHC W MOUTHPIECE 97
RESTORIL 50
REVATIO 25
REVLIMID 11
RIBAVIRIN 7
RIFAXIMIN 4
RISPERDAL CONSTA 44
RISPERIDONE (CONSTA) 44
RITUXAN 13
RITUXIMAB 13
RIVA OXAZEPAM 49
RIVA-ALPRAZOLAM 47
RIVA-ATOMOXETINE 54
RIVA-CLONAZEPAM 37
RIVACOCET 28
RIVA-CYCLOBENZAPRINE 21
RIVA-DONEPEZIL 15
RIVA-DUTASTERIDE 79
RIVA-FINASTERIDE 80
RIVA-GABAPENTIN 39
RIVA-LANSOPRAZOLE 65
RIVA-MONTELUKAST 60
RIVA-MOXIFLOXACIN 3
RIVA-OMEPRAZOLE DR 67
RIVA-PANTOPRAZOLE 69
RIVA-PREGABALIN 41
RIVA-RABEPRAZOLE 70
RIVA-RABEPRAZOLE EC 69
RIVA-RIZATRIPTAN ODT 51
RIVAROXABAN 24
RIVASA 27
RIVASTIGMINE 17
RIVASTIGMINE HYDROGEN TARTRATE 17
RIVA-ZOLMITRIPTAN 53
RIVOTRIL 37
RIZATRIPTAN BENZOATE 51
RIZATRIPTAN ODT 51
RIZATRIPTAN RDT 51
ROSIGLITAZONE MALEATE 74
ROTIGOTINE 53
RUFINAMIDE 42
RUGBY NICOTINE POLACRILEX GUM 21
SALMETEROL XINAFOATE 20
SALMETEROL XINAFOATE, FLUTICASONE PROPIONATE 21
SANDOZ ALMOTRIPTAN 50
SANDOZ ATOMOXETINE 54
SANDOZ BOSENTAN 26
SANDOZ BUPROPION SR 43
SANDOZ CLONAZEPAM 37
SANDOZ CYCLOSPORINE 93
SANDOZ DONEPEZIL 15
SANDOZ DUTASTERIDE 79
SANDOZ FENTANYL 29
SANDOZ FINASTERIDE 80
SANDOZ LANSOPRAZOLE 65
SANDOZ LEVOFLOXACIN 2
SANDOZ LINEZOLID 4
SANDOZ METHYLPHENIDATE SR 46
SANDOZ MINOCYCLINE 3
SANDOZ MONTELUKAST 59
SANDOZ MORPHINE SR 33
SANDOZ MOXIFLOXACIN 3
SANDOZ MYCOPHENOLATE 94
SANDOZ NARATRIPTAN 51
SANDOZ OMEPRAZOLE 67
SANDOZ OXYCODONE/ACETAMINOPHEN 28
SANDOZ PANTOPRAZOLE 69
SANDOZ PIOGLITAZONE 73
SANDOZ PREGABALIN 41
SANDOZ RABEPRAZOLE 69
SANDOZ RIVASTIGMINE 17
SANDOZ RIZATRIPTAN ODT 51
SANDOZ SUMATRIPTAN 52
SANDOZ TACROLIMUS 95
SANDOZ VORICONAZOLE 5
SANDOZ ZOLMITRIPTAN 53
SANDOZ ZOLMITRIPTAN ODT 53
SAPHRIS 44
SAXAGLIPTIN HYDROCHLORIDE 71
SAXAGLIPTIN HYDROCHLORIDE, METFORMIN HYDROCHLORIDE 72
SECUKINUMAB 75
SEEBRI BREEZHALER 18
SEPTA DONEPEZIL 15
SEPTA-ZOLMITRIPTAN-ODT 53
SEREVENT DISKHALER 20
SEREVENT DISKUS 20
SEVELAMER HYDROCHLORIDE 58
SIDEKICK 57
SILDENAFIL CITRATE 25
SIMEPREVIR SODIUM 7
SIMPONI 88
SINGULAIR 59
SIROLIMUS 94
SITAGLIPTIN PHOSPHATE MONOHYDRATE 72
SITAGLIPTIN PHOSPHATE MONOHYDRATE, METFORMIN HYDROCHLORIDE 72

SOFOSBUVIR **7**
SOFOSBUVIR, LEDIPASVIR **8**
SOFOSBUVIR, VELPATASVIR **8**
SOVALDI 7
SPACER DEVICE **96**
SPIRIT TEST STRIP (ON) 57
SPIRIVA 18
SPIRIVA RESPIMAT 18
STATEX 33
STELARA 79
STRATTERA 54
SUBOXONE 35
SUMATRIPTAN 52
SUMATRIPTAN DF 52
SUMATRIPTAN SUCCINATE **52**
SUNITINIB MALATE **13**
SUPEUDOL 34
SURE STEP 57
SURETEST (ON) 57
SUTENT 13
SYMBICORT 100 TURBUHALER 20
SYMBICORT 200 TURBUHALER 20
TACROLIMUS (PROTOPIC) **76**
TACROLIMUS MONOHYDRATE **95**
TADALAFIL **25**
TAFINLAR 9
TARCEVA 10
TARO-DICLOFENAC 27
TARO-SUMATRIPTAN 52
TARO-TEMOZOLOMIDE 13
TARO-ZOLEDRONIC ACID 81
TECTA 68
TEMAZEPAM **50**
TEMAZEPAM 50
TEMODAL 13
TEMOZOLOMIDE **13**
TEMPRA CHILDREN'S 35
TEMPRA CHILDREN'S DOUBLE STRENGTH 35
TEMPRA INFANT 35
TENDER-1 17MM/110CM 98
TENDER-1 17MM/60CM 98
TENDER-1 17MM/80CM 98
TENDER-1 MINI INF SET 13MM/110CM 98
TENDER-1 MINI INFSET 13MM/60CM 98
TENDER-1 MINI INFSET 13MM/80CM 98
TENDER-2 17MM/110CM 98
TENDER-2 17MM/60CM 98
TENDER-2 17MM/80CM 98
TENDER-2 MINI INF SET 13MM/110CM 98
TENDER-2 MINI INFSET 13MM/60CM 98
TENDER-2 MINI INFSET 13MM/80CM 98
TENOFOVIR DISOPROXIL FUMARATE **5**
TEVA-ALPRAZOLAM 47
TEVA-ATOMOXETINE 54
TEVA-BOSENTAN 26
TEVA-BROMAZEPAM 47
TEVA-CLONAZEPAM 37
TEVA-CODEINE 29
TEVA-CYCLOBENZAPRINE 21
TEVA-DONEPEZIL 15
TEVA-DUTASTERIDE 79
TEVA-EMTEC-30 28
TEVA-ERLOTINIB 10
TEVA-FENTANYL 29
TEVA-FINASTERIDE 80
TEVA-GABAPENTIN 39
TEVA-GALANTAMINE ER 16
TEVA-HYDROMORPHONE 31
TEVA-IMATINIB 10
TEVA-LANSOPRAZOLE 65
TEVA-LEVOFLOXACIN 2
TEVA-LORAZEPAM 48
TEVA-METHYLPHENIDATE 46
TEVA-MINOCYCLINE 3
TEVA-MONTELUKAST 60
TEVA-MORPHINE SR 33
TEVA-MOXIFLOXACIN 3
TEVA-MYCOPHENOLATE 94
TEVA-NABILONE 64
TEVA-NARATRIPTAN 50
TEVA-OMEPRAZOLE 67
TEVA-OXYCOCET 28
TEVA-OXYCODAN 28
TEVA-PANTOPRAZOLE 69
TEVA-PANTOPRAZOLE MAGNESIUM 68
TEVA-PIOGLITAZONE 73
TEVA-PREGABALIN 41
TEVA-PROGESTERONE 75
TEVA-RABEPRAZOLE 70
TEVA-RALOXIFENE 71
TEVA-RIZATRIPTAN ODT 51
TEVA-SILDENAFIL R 25
TEVA-SUMATRIPTAN 52
TEVA-SUMATRIPTAN DF 52
TEVA-TEMAZEPAM 50
TEVA-TOLTERODINE 76
TEVA-VORICONAZOLE 5
TEVA-ZOLMITRIPTAN 53
TEVA-ZOLMITRIPTAN OD 53
THRIVE NICOTINE LOZENGES 22
THRIVE NICOTINELL GUM 22
TIOTROPIUM BROMIDE MONOHYDRATE **18**
TIZANIDINE 21
TIZANIDINE HYDROCHLORIDE **21**
TOBRAMYCIN 1
TOBRAMYCIN **1**
TOBRAMYCINE 1
TOCILIZUMAB (IV) **92**
TOCILIZUMAB (SC) **93**
TOFACITINIB CITRATE **93**
TOLTERODINE TARTRATE **76**
TOVIAZ 76
TRACLEER 26
TRAJENTA 71
TRAMETINIB **14**
TRANSDERMAL NICOTINE 22
TRANSDERMAL NICOTINE PATCHDAY 23
TRAVEL 64
TRAVEL ON 64
TRIATEC-30 28
TRIAZOLAM 50
TRIAZOLAM **50**
TRIMEBUTINE 18
TRIMEBUTINE MALEATE **18**
TROSEC 77
TROSPIUM CHLORIDE **77**
TRUE TRACK 58
TRUETEST 58
TUDORZA GENUAIR 18
TYLENOL 35
TYLENOL EXTRA STRENGTH 37
TYLENOL JR STRENGTH FASTMELTS 36
TYLENOL JUNIOR STRENGTH 37
TYLENOL WITH CODEINE NO.2 28
TYLENOL WITH CODEINE NO.3 28
ULIPRISTAL ACETATE **71**
ULORIC 80
ULTIBRO BREEZHALER 18
ULTRAFLEX 1 10MM/110CM 98
ULTRAFLEX 1 10MM/60CM 98
ULTRAFLEX 1 10MM/80CM 98
ULTRAFLEX 1 8MM/110CM 98
ULTRAFLEX 1 8MM/60CM 99
ULTRAFLEX 1 8MM/80CM 99
UMECLIDINIUM BROMIDE **18**
UMECLIDINIUM BROMIDE, VILANTEROL TRIFENATATE **19**
USTEKINUMAB **79**
VALIUM 48
VALSARTAN, SACUBITRIL **27**
VAL-VANCOMYCIN 4
VANCOMYCIN 4
VANCOMYCIN HYDROCHLORIDE (INJECTION) **4**
VAN-FINASTERIDE 80
VAN-MYCOPHENOLATE 94
VAN-OMEPRAZOLE 67
VAN-PIOGLITAZONE 73
VAN-RIZATRIPTAN 51
VAN-RIZATRIPTAN ODT 52
VAN-ZOLMITRIPTAN ODT 53
VARENICLINE TARTRATE **23**
VEDOLIZUMAB **95**
VEMURAFENIB **14**
VERTEPORFIN **63**
VFEND 5
VIMPAT 40
VIREAD 5
VISANNE 75
VISUDYNE 63
VITAMIN E 77
VITAMIN E **77**
VOLIBRIS 26
VORICONAZOLE **5**
VOTRIENT 12
VYVANSE 45
WAMPOLE COMPLETE MULT-PRE AND POST NATAL WITH FOLIC ACID 78
WELLBUTRIN SR 43
WELLBUTRIN XL 43
XANAX 47
XANAX TS 47
XARELTO 24
XELJANZ 93
XEOMIN 96
XGEVA 80

XIGDUO 73
XOLAIR 61
XTANDI 10
ZAFIRLUKAST **61**
ZAXINE 4
ZELBORAF 14
ZENHALE 20
ZEPATIER 6
ZOLEDRONIC ACID 81
ZOLEDRONIC ACID MONOHYDRATE **81**
ZOLMITRIPTAN **53**
ZOLMITRIPTAN 53
ZOLMITRIPTAN ODT 53
ZOMIG 53
ZOMIG RAPIMELT 53
ZYBAN 43
ZYDELIG 10
ZYTIGA 8
ZYVOXAM 3

APPENDIX B
SPECIAL FORMULARY FOR CHRONIC RENAL FAILURE PATIENTS

The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional products formulated for renal patients) that are covered for identified eligible NIHB clients in chronic renal failure.
These drugs are covered in addition to the drugs and products listed in the NIHB Drug Benefit List.

08:00 ANTI-INFECTIVE AGENTS

08:12.02 AMINOGLYCOSIDES

GENTAMICIN SULFATE

10MG/ML INJECTION		
02225123	CIDOMYCIN	UNK
10MG SOLUTION		
02470462	GENTAMICIN	TEL
40MG SOLUTION		
02457008	GENTAMICIN	TEL

08:12.06 CEPHALOSPORINS

CEFAZOLIN SODIUM

500MG POWDER FOR SOLUTION		
02437104	CEFAZOLIN	RAX
1G POWDER FOR SOLUTION		
02465469	CEFAZOLIN	UNK
10G POWDER FOR SOLUTION		
02452162	CEFAZOLIN	FKD
02465477	CEFAZOLIN	UNK
20G POWDER FOR SOLUTION		
02237141	CEFAZOLIN	FKD
100G POWDER FOR SOLUTION		
02401029	CEFAZOLIN	FKD

20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA

25MCG/ML SOLUTION		
02392313	ARANESP	AMG
40MCG/ML SOLUTION		
02392321	ARANESP	AMG
60MCG/ML SOLUTION		
02246348	ARANESP	AMG
100MCG/ML SOLUTION		
02391740	ARANESP	AMG
02391759	ARANESP	AMG
02392348	ARANESP	AMG
99004917	ARANESP	AMG
99004925	ARANESP	AMG
200MCG/ML SOLUTION		
02391767	ARANESP	AMG
02391775	ARANESP	AMG
02391783	ARANESP	AMG
02392356	ARANESP	AMG
99004909	ARANESP	AMG
99004933	ARANESP	AMG
500MCG/ML SOLUTION		
02391791	ARANESP	AMG

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA

500MCG/ML SOLUTION		
02391805	ARANESP	AMG
02391821	ARANESP	AMG
02392364	ARANESP	AMG
09857185	ARANESP	AMG

EPOETIN ALFA

1,000U/0.5ML SOLUTION		
02231583	EPREX	JSO
2,000U/0.5ML SOLUTION		
02231584	EPREX	JSO
3,000U/0.3ML SOLUTION		
02231585	EPREX	JSO
4,000U/0.4ML SOLUTION		
02231586	EPREX	JSO
5000U/0.5ML SOLUTION		
02243400	EPREX	JSO
6000U/0.6ML SOLUTION		
02243401	EPREX	JSO
8000U/0.8ML SOLUTION		
02243403	EPREX	JSO
10,000/ML SOLUTION		
02231587	EPREX	JSO
20,000U/0.5ML SOLUTION		
02243239	EPREX	JSO
30,000U/0.75ML SOLUTION		
02288680	EPREX	JSO
40,000U/ML SOLUTION		
02240722	EPREX	JSO

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:12.00 REPLACEMENT PREPARATIONS

CALCIUM

500MG CAPSULE		
00648353	CALSAN	NVC
250MG TABLET		
00645958	CALCIUM	NOP
625MG TABLET (COATED)		
00682047	APOCAL	APX

CALCIUM CARB-GLUCONOLACTATE

500MG TABLET		
02232482	CALCIUM SANDOZ FORTE	GSK
1,000MG TABLET		
02232483	CALCIUM-SANDOZ GRAMCAL	GSK

SODIUM PHOSPHATE

123MG POWDER FOR SOLUTION		
80027202	PHOSPHATE-NOVARTIS	NVR

The Special Formulary for Chronic Renal Failure Patients defines selected drugs (for example: darbepoetin alfa, calcium products, water-soluble multivitamin products and selected nutritional products formulated for renal patients) that are covered for identified eligible NIHB clients in chronic renal failure.
These drugs are covered in addition to the drugs and products listed in the NIHB Drug Benefit List.

40:12.00 REPLACEMENT PREPARATIONS

SODIUM PHOSPHATE

500MG TABLET

00225819 PHOSPHATE-NOVARTIS NVC

ZINC GLUCONATE

50MG TABLET

00503169 ZINC VTH
00505463 ZINC JAM

56:00 GASTROINTESTINAL DRUGS

56:04.00 ANTACIDS AND ADSORBENTS

ALUMINUM HYDROXIDE

500MG CAPSULE

02135620 BASALJEL AUP

325MG/5ML ORAL LIQUID

02125862 AMPHOJEL AUP

320MG/ML SUSPENSION

00572527 ALUGEL ATL

600MG TABLET

02124971 AMPHOJEL AUP

CALCIUM

500MG TABLET

01970240 TUMS GSK

750MG TABLET

01967932 TUMS EXTRA STRENGTH GSK

1,000MG TABLET

02151138 TUMS ULTRA STRENGTH GSK

SODIUM BICARBONATE

500MG TABLET

80030520 JAMP-SODIUM BICARBONATE JMP
80022194 SANDOZ SODIUM BICARBONATE SDZ

56:12.00 CATHARTICS AND LAXATIVES

SODIUM PHOSPHATE

TABLET

80047562 JAMP-SODIUM PHOSPHATE JMP

84:00 SKIN AND MUCOUS MEMBRANE AGENTS (SMMA)

84:04.04 SMMA - ANTIBIOTICS

GENTAMICIN SULFATE

1MG OINTMENT

00872881 PMS-GENTAMICIN PMS

88:00 VITAMINS

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS

CAPSULE

00123803 B COMPLEX PLUS C JAM

88:28.00 MULTIVITAMIN PREPARATIONS

MULTIVITAMINS

TABLET

80007498 BC VITAMINS WNP
02245391 DIAMINE EUR
80001432 RENAVITE MAC
00558796 STRESS PLEX JAM

1MG TABLET

80020788 JAMP-VITAMINS B C JMP

300MCG TABLET

80063438 M-PLAVITE MAN

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

NUTRITIONAL SUPPLEMENT

ORAL LIQUID

09853154 BOOST FRUIT BEVERAGE NES
95999970 BOOST HIPROTEIN NES
95999963 BOOST ORIGINAL NES
95999975 BOOST PLUS NES
97904341 ENSURE ABB
00601054 ENSURE HIGH PROTEIN ABB
97904333 ENSURE PLUS ABB
97904317 ENSURE WITH FIBRE ABB
00920347 GLUCERNA ABB
99004267 GLUCERNA ABB
09854392 GLUCERNA TUBE FEEDING ABB
09854393 GLUCERNA TUBE FEEDING ABB
09853723 NEPRO ABB
99002639 NEPRO ABB
99100702 NEPRO CARB STEADY ABB
00907995 NOVASOURCE NVC
09854258 NOVASOURCE NES
09853731 SUPLENA ABB
99002647 SUPLENA ABB

POWDER

09991056 RESOURCE BENEPROTEIN NVC

ALUGEL	2
ALUMINUM HYDROXIDE	**2**
AMPHOJEL	2
APOCAL	1
ARANESP	1
B COMPLEX PLUS C	2
BASALJEL	2
BC VITAMINS	2
BOOST FRUIT BEVERAGE	2
BOOST HIPROTEIN	2
BOOST ORIGINAL	2
BOOST PLUS	2
CALCIUM	1
CALCIUM	**1**
CALCIUM CARB-GLUCONOLACTATE	**1**
CALCIUM SANDOZ FORTE	1
CALCIUM-SANDOZ GRAMCAL	1
CALSAN	1
CEFAZOLIN	1
CEFAZOLIN SODIUM	**1**
CIDOMYCIN	1
DARBEPOETIN ALFA	**1**
DIAMINE	2
ENSURE	2
ENSURE HIGH PROTEIN	2
ENSURE PLUS	2
ENSURE WITH FIBRE	2
EPOETIN ALFA	**1**
EPREX	1
GENTAMICIN	1
GENTAMICIN SULFATE	**1**
GLUCERNA	2
GLUCERNA TUBE FEEDING	2
JAMP-SODIUM BICARBONATE	2
JAMP-SODIUM PHOSPHATE	2
JAMP-VITAMINS B C	2
M-PLAVITE	2
MULTIVITAMINS	**2**
NEPRO	2
NEPRO CARB STEADY	2
NOVASOURCE	2
NUTRITIONAL SUPPLEMENT	**2**
PHOSPHATE-NOVARTIS	1
PMS-GENTAMICIN	2
RENAVITE	2
RESOURCE BENEPROTEIN	2
SANDOZ SODIUM BICARBONATE	2
SODIUM BICARBONATE	**2**
SODIUM PHOSPHATE	**1**
STRESS PLEX	2
SUPLENA	2
TUMS	2
TUMS EXTRA STRENGTH	2
TUMS ULTRA STRENGTH	2
ZINC	2
ZINC GLUCONATE	**2**

APPENDIX C
PALLIATIVE CARE FORMULARY

Effective April 1, 2009, recipients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs below will generate a Palliative Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary if the following criteria are met:

The recipient:
1. is not receiving care in a provincially funded hospital or provincially funded long-term care facility and
2. has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less

Once approved, the recipient will be eligible for all medications on the Palliative Care Formulary for six months without the need for further prior approval. If coverage is required beyond the initial six months, an additional six months may be granted upon receipt of another Palliative Care Application Form completed.
Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

12:00 AUTONOMIC DRUGS

12:08.08 ANTIMUSCARINICS / ANTISPASMODICS

ATROPINE SULFATE

0.4MG/ML SOLUTION

02094681	ATROPINE	ALV
00960624	ATROPINE SULFATE	UNK

0.6MG/ML SOLUTION

00012076	ATROPINE SULFATE	GSK
00392693	ATROPINE SULFATE	SDZ
00392782	ATROPINE SULFATE	SDZ

GLYCOPYRROLATE

0.2MG LIQUID

02382849	GLYCOPYRROLATE MULTIDOSE	OMG

0.2MG/ML LIQUID

02039508	GLYCOPYRROLATE	SDZ
02382857	GLYCOPYRROLATE	OMG

HYOSCINE BUTYLBROMIDE

20MG/ML SOLUTION

00363839	BUSCOPAN	SAC
02229868	HYOSCINE BUTYLBROMIDE	SDZ

SCOPOLAMINE HYDROBROMIDE

0.4MG/ML SOLUTION

00541869	SCOPOLAMINE	HOS
02242810	SCOPOLAMINE	OMG

0.6MG/ML SOLUTION

00541877	SCOPOLAMINE	HOS
02242811	SCOPOLAMINE	OMG

28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:04.92 GENERAL ANESTHETICS, MISC.

KETAMINE HYDROCHLORIDE

10MG/ML SOLUTION

00224391	KETALAR	ERF
02246795	KETAMINE	SDZ

28:04.92 GENERAL ANESTHETICS, MISC.

KETAMINE HYDROCHLORIDE

10MG/ML SOLUTION

02387301	KETAMINE	SDZ

50MG/ML SOLUTION

00224405	KETALAR	ERF
02246796	KETAMINE	SDZ
02387328	KETAMINE	SDZ
02387336	KETAMINE	SDZ

28:08.08 OPIATE AGONISTS

EXTEMPORANEOUS MIXTURE

INJECTION

99506019	FENTANYL STERILE INFUSION	UNK
99506017	HYDROMORPHONE HP STERILE INFUSION	UNK
99506018	MORPHINE HP STERILE INFUSION	UNK

FENTANYL

12MCG/HR PATCH

02454440	APO-FENTANYL MATRIX	APX
02334186	DURAGESIC	JSO
99100480	FENTANYL	JNO
02376768	PAT-FENTANYL MATRIX	KLA

25MCG/HR PATCH

02304120	FENTANYL TRANSDERMAL SYSTEM	ACG
02376776	PAT-FENTANYL MATRIX	KLA
02325403	RAN-FENTANYL MATRIX	RBY

37MCG/HR PATCH

02386860	CO FENTANYL	OBT
02327139	SANDOZ FENTANYL	SDZ

50MCG/HR PATCH

02304139	FENTANYL TRANSDERMAL SYSTEM	ACG
02376784	PAT-FENTANYL MATRIX	KLA
02325411	RAN-FENTANYL MATRIX	RBY

75MCG/HR PATCH

02304147	FENTANYL TRANSDERMAL SYSTEM	ACG

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28:08.08 OPIATE AGONISTS

FENTANYL

75MCG/HR PATCH

02376792	PAT-FENTANYL MATRIX	KLA
02325438	RAN-FENTANYL MATRIX	RBY

100MCG/HR PATCH

02304155	FENTANYL TRANSDERMAL SYSTEM	ACG
02376806	PAT-FENTANYL MATRIX	KLA
02325446	RAN-FENTANYL MATRIX	RBY

FENTANYL CITRATE

50MCG/ML SOLUTION

00888346	FENTANYL CITRATE	HOS
02240434	FENTANYL CITRATE	SDZ

HYDROMORPHONE HYDROCHLORIDE

2MG/ML SOLUTION

02145901	HYDROMORPHONE	SDZ

10MG SOLUTION

02460610	HYDROMORPHONE HYDROCHLORIDE HP 10	RAX

10MG/ML SOLUTION

02145928	HYDROMORPHONE HP	SDZ

20MG/ML SOLUTION

02145936	HYDROMORPHONE HP	SDZ

50MG/ML SOLUTION

02146126	HYDROMORPHONE HP	SDZ
99003163	HYDROMORPHONE HP	UNK

100MG/ML SOLUTION

02244797	HYDROMORPHONE HP FORTE	SDZ

METHADONE HYDROCHLORIDE (BC ONLY)

POWDER

09991180	METHADONE PDR (PAIN)	UNK
09991552	METHADONE PDR (PALLIATIVE)	UNK

METHADONE HYDROCHLORIDE (METADOL)

1MG/ML SOLUTION

02247694	METADOL	PAL

1MG TABLET

02247698	METADOL	PAL

28:08.08 OPIATE AGONISTS

METHADONE HYDROCHLORIDE (METADOL)

5MG TABLET

02247699	METADOL	PAL

10MG TABLET

02247700	METADOL	PAL

25MG TABLET

02247701	METADOL	PAL

MORPHINE SULFATE

2MG/ML LIQUID

02242484	MORPHINE SULFATE	SDZ

10MG LIQUID

00392588	MORPHINE SULFATE	SDZ

15MG LIQUID

00392561	MORPHINE SULFATE	SDZ

50MG/ML LIQUID

02137267	MORPHINE SULPHATE	HOS

0.5MG/ML SOLUTION

02021056	MORPHINE LP EPIDURAL	SDZ
01949047	MORPHINE-EPD	HOS

1MG/ML SOLUTION

02021048	MORPHINE LP	SDZ
01980696	MORPHINE SULFATE	SDZ
01949055	MORPHINE-EPD	HOS

2MG/ML SOLUTION

00850314	MORPHINE SULFATE	HOS
01964437	MORPHINE SULFATE	SDZ

5MG/ML SOLUTION

01964429	MORPHINE SULFATE	SDZ

10MG/ML SOLUTION

00850322	MORPHINE SULFATE	HOS

25MG/ML SOLUTION

00676411	MORPHINE HP	SDZ

50MG/ML SOLUTION

00617288	MORPHINE HP	SDZ

Effective April 1, 2009, recipients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

Requests for any of the DINs below will generate a Palliative Care Application Form, faxed to the prescribing physician. Once completed and submitted, the recipient will be eligible for all medications on the Palliative Care Formulary if the following criteria are met:

The recipient:
1. is not receiving care in a provincially funded hospital or provincially funded long-term care facility and
2. has been diagnosed with a terminal illness or disease which is expected to be the primary cause of death within six months or less

Once approved, the recipient will be eligible for all medications on the Palliative Care Formulary for six months without the need for further prior approval. If coverage is required beyond the initial six months, an additional six months may be granted upon receipt of another Palliative Care Application Form completed.
Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

28:12.04 ANTICONVULSANTS - BARBITURATES

PHENOBARBITAL

30MG SOLUTION

02304082	PHENOBARBITAL SODIUM	SDZ

120MG SOLUTION

09857296	PHENOBARBITAL	HOS
02304090	PHENOBARBITAL SODIUM	SDZ

28:12.12 ANTICONVULSANTS - HYDANTOINS

PHENYTOIN

50MG LIQUID

00780626	PHENYTOIN SODIUM	SDZ

28:16.08 ANTIPSYCHOTIC AGENTS

METHOTRIMEPRAZINE HYDROCHLORIDE

25MG/ML SOLUTION

01927698	NOZINAN	SAC

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

DIAZEPAM

5MG/ML SOLUTION

00399728	DIAZEPAM	SDZ
02386143	DIAZEPAM	SDZ

DIAZEPAM (DIASTAT)

5MG/ML GEL

02238162	DIASTAT	VAE
09853340	DIASTAT 2X10MG RECTAL PACK	ELN
09853430	DIASTAT 2X15MG RECTAL PACK	ELN

LORAZEPAM

4MG/ML LIQUID

02243278	LORAZEPAM	SDZ

2MG/ML SOLUTION

02438704	LORAZEPAM	SDZ

28:24.08 ANXIOLYTICS, SEDATIVES AND HYPNOTICS - BENZODIAZEPINES

MIDAZOLAM

1MG/ML SOLUTION

02240285	MIDAZOLAM	SDZ
02242904	MIDAZOLAM	FKD
02243934	MIDAZOLAM	NOP

5MG/ML SOLUTION

02240286	MIDAZOLAM	SDZ
02242905	MIDAZOLAM	FKD
02243935	MIDAZOLAM	NOP
02382903	MIDAZOLAM	SDZ

40:00 ELECTROLYTIC, CALORIC, AND WATER BALANCE

40:28.08 LOOP DIURETICS

FUROSEMIDE

10MG LIQUID

00527033	FUROSEMIDE	SDZ

10MG/ML SOLUTION

02382539	FUROSEMIDE	SDZ
02384094	FUROSEMIDE	ALV

52:00 EYE, EAR, NOSE AND THROAT (EENT)

52:92.00 MISCELLANEOUS EENT DRUGS

ARTIFICIAL SALIVA

0.05MG SPRAY

02238696	MOISTIR	PMS

56:00 GASTROINTESTINAL DRUGS

56:08.00 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HYDROCHLORIDE, ATROPINE SULFATE

2.5MG & 0.025MG TABLET

00036323	LOMOTIL	PFI

Effective April 1, 2009, recipients diagnosed with a terminal illness and are near the end of life will be eligible to receive a list of supplemental benefits that are not included in the NIHB Drug Benefit List. The Palliative Care Formulary includes medications used to provide comfort to those near the end of life.

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Once approved, the recipient will be eligible for all medications on the Palliative Care Formulary for six months without the need for further prior approval. If coverage is required beyond the initial six months, an additional six months may be granted upon receipt of another Palliative Care Application Form completed.
Please note: During the six month coverage period, a maximum 30 day supply will be reimbursed at any one time.

56:22.20 5-HT3 RECEPTOR ANTAGONISTS

GRANISETRON HYDROCHLORIDE

1MG LIQUID

02322765	GRANISETRON HYDROCHLORIDE	OMG

1MG/ML SOLUTION

02385414	GRANISETRON	SDZ

ONDANSETRON HYDROCHLORIDE

2MG/ML SOLUTION

02265524	ONDANSETRON	TEV
02274418	ONDANSETRON	SDZ
02279428	ONDANSETRON	SDZ
02390019	ONDANSETRON	MYL
02390051	ONDANSETRON	MYL

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

0.25MG CAPSULE

02441497	APO-NABILONE	APX
02345897	APP-NABILONE	UNK
02380897	PMS-NABILONE	PMS

0.5MG CAPSULE

02441500	APO-NABILONE	APX
02345927	APP-NABILONE	UNK

1MG CAPSULE

02441519	APO-NABILONE	APX
02345935	APP-NABILONE	UNK

SCOPOLAMINE

1.5MG PATCH

00550094	TRANSDERM-V	NVC
80024336	TRANSDERM-V	NVR

56:28.12 HISTAMINE H2-ANTAGONISTS

RANITIDINE HYDROCHLORIDE

25MG/ML SOLUTION

02256711	RANITIDINE	SDZ

56:32.00 PROKINETIC AGENTS

METOCLOPRAMIDE HYDROCHLORIDE

5MG/ML LIQUID

02185431	METOCLOPRAMIDE	SDZ
02243563	METOCLOPRAMIDE OMEGA	OMG

56:92.00 MISCELLANEOUS GI DRUGS

METHYLNALTREXONE BROMIDE

20MG SOLUTION

02308215	RELISTOR	SLX
02356481	RELISTOR	SLX
02356503	RELISTOR	SLX

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

ADMINISTRATION DIN

MISCELLANEOUS

91500004	STERILE PREPERATION FEE	UNK

NUTRITIONAL SUPPLEMENT

ORAL LIQUID

09853154	BOOST FRUIT BEVERAGE	NES
95999970	BOOST HIPROTEIN	NES
95999963	BOOST ORIGINAL	NES
95999975	BOOST PLUS	NES
97904341	ENSURE	ABB
00801054	ENSURE HIGH PROTEIN	ABB
97904333	ENSURE PLUS	ABB
97904317	ENSURE WITH FIBRE	ABB

ADMINISTRATION DIN	**4**
APO-FENTANYL MATRIX	1
APO-NABILONE	4
APP-NABILONE	4
ARTIFICIAL SALIVA	**3**
ATROPINE	1
ATROPINE SULFATE	**1**
ATROPINE SULFATE	1
BOOST FRUIT BEVERAGE	4
BOOST HIPROTEIN	4
BOOST ORIGINAL	4
BOOST PLUS	4
BUSCOPAN	1
CO FENTANYL	1
DIASTAT	3
DIASTAT 2X10MG RECTAL PACK	3
DIASTAT 2X15MG RECTAL PACK	3
DIAZEPAM	3
DIAZEPAM	**3**
DIAZEPAM (DIASTAT)	**3**
DIPHENOXYLATE HYDROCHLORIDE, ATROPINE SULFATE	**3**
DURAGESIC	1
ENSURE	4
ENSURE HIGH PROTEIN	4
ENSURE PLUS	4
ENSURE WITH FIBRE	4
EXTEMPORANEOUS MIXTURE	**1**
FENTANYL	**1**
FENTANYL	1
FENTANYL CITRATE	**2**
FENTANYL CITRATE	2
FENTANYL STERILE INFUSION	1
FENTANYL TRANSDERMAL SYSTEM	1
FUROSEMIDE	**3**
FUROSEMIDE	3
GLYCOPYRROLATE	**1**
GLYCOPYRROLATE	1
GLYCOPYRROLATE MULTIDOSE	1
GRANISETRON	4
GRANISETRON HYDROCHLORIDE	**4**
GRANISETRON HYDROCHLORIDE	4
HYDROMORPHONE	2
HYDROMORPHONE HP	2
HYDROMORPHONE HP FORTE	2
HYDROMORPHONE HP STERILE INFUSION	1
HYDROMORPHONE HYDROCHLORIDE	**2**
HYDROMORPHONE HYDROCHLORIDE HP 10	2
HYOSCINE BUTYLBROMIDE	1
HYOSCINE BUTYLBROMIDE	**1**
KETALAR	1
KETAMINE	1
KETAMINE HYDROCHLORIDE	**1**
LOMOTIL	3
LORAZEPAM	**3**
LORAZEPAM	3
METADOL	2
METHADONE HYDROCHLORIDE (BC ONLY)	**2**
METHADONE HYDROCHLORIDE (METADOL)	**2**
METHADONE PDR (PAIN)	2
METHADONE PDR (PALLIATIVE)	2
METHOTRIMEPRAZINE HYDROCHLORIDE	**3**
METHYLNALTREXONE BROMIDE	**4**
METOCLOPRAMIDE	4
METOCLOPRAMIDE HYDROCHLORIDE	**4**
METOCLOPRAMIDE OMEGA	4
MIDAZOLAM	**3**
MIDAZOLAM	3
MOISTIR	3
MORPHINE HP	2
MORPHINE HP STERILE INFUSION	1
MORPHINE LP	2
MORPHINE LP EPIDURAL	2
MORPHINE SULFATE	2
MORPHINE SULFATE	**2**
MORPHINE SULPHATE	2
MORPHINE-EPD	2
NABILONE	**4**
NOZINAN	3
NUTRITIONAL SUPPLEMENT	**4**
ONDANSETRON	4
ONDANSETRON HYDROCHLORIDE	**4**
PAT-FENTANYL MATRIX	1
PHENOBARBITAL	3
PHENOBARBITAL	**3**
PHENOBARBITAL SODIUM	3
PHENYTOIN	**3**
PHENYTOIN SODIUM	3
PMS-NABILONE	4
RAN-FENTANYL MATRIX	1
RANITIDINE	4
RANITIDINE HYDROCHLORIDE	**4**
RELISTOR	4
SANDOZ FENTANYL	1
SCOPOLAMINE	1
SCOPOLAMINE	**4**
SCOPOLAMINE HYDROBROMIDE	**1**
STERILE PREPERATION FEE	4
TRANSDERM-V	4

APPENDIX D
FORMULARY FOR ADJUNCT MEDICATIONS USED DURING ACTIVE CANCER TREATMENT

The NIHB Program has established a new formulary to streamline access to adjunctive (non-chemotherapy) medications frequently used by clients undergoing active cancer treatment.

Clients who are approved for oral chemotherapy drugs are given access to all of the medications in the formulary. Additionally, clients who request, and are approved, for one of the medications on the formulary for a cancer-related indication are also granted access.

Clients are automatically enrolled for a period of six months. If cancer treatment is of a longer duration, access to the formulary will be granted to align with the treatment duration. In the event that treatment duration is not known and the treatment plan extends beyond six months, access to this formulary may be extended upon request.

08:00 ANTI-INFECTIVE AGENTS

08:12.24 TETRACYCLINES

MINOCYCLINE HYDROCHLORIDE

50MG CAPSULE

02084090	APO-MINOCYCLINE	APX
02239667	DOM-MINOCYCLINE	DPC
02153394	MINOCYCLINE	PDL
02287226	MINOCYCLINE	SAN
02230735	MYLAN-MINOCYCLINE	MYL
02294419	PMS-MINOCYCLINE	PMS
02237313	SANDOZ MINOCYCLINE	SDZ
02108143	TEVA-MINOCYCLINE	TEV

100MG CAPSULE

02084104	APO-MINOCYCLINE	APX
02239668	DOM-MINOCYCLINE	DPC
02154366	MINOCYCLINE	PDL
02239982	MINOCYCLINE	IVX
02287234	MINOCYCLINE	SAN
02230736	MYLAN-MINOCYCLINE	MYL
02294427	PMS-MINOCYCLINE	PMS
02237314	SANDOZ MINOCYCLINE	SDZ
02108151	TEVA-MINOCYCLINE	TEV

20:00 BLOOD FORMATION COAGULATION AND THROMBOSIS

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA

25MCG/ML SOLUTION

02392313	ARANESP	AMG

40MCG/ML SOLUTION

02392321	ARANESP	AMG

60MCG/ML SOLUTION

02246348	ARANESP	AMG

100MCG/ML SOLUTION

02391740	ARANESP	AMG
02391759	ARANESP	AMG
02392348	ARANESP	AMG
99004917	ARANESP	AMG
99004925	ARANESP	AMG

200MCG/ML SOLUTION

02391767	ARANESP	AMG
02391775	ARANESP	AMG
02391783	ARANESP	AMG

20:16.00 HEMATOPOIETIC AGENTS

DARBEPOETIN ALFA

200MCG/ML SOLUTION

02392356	ARANESP	AMG
99004909	ARANESP	AMG
99004933	ARANESP	AMG

500MCG/ML SOLUTION

02391791	ARANESP	AMG
02391805	ARANESP	AMG
02391821	ARANESP	AMG
02392364	ARANESP	AMG
09857185	ARANESP	AMG

EPOETIN ALFA

1,000U/0.5ML SOLUTION

02231583	EPREX	JSO

2,000U/0.5ML SOLUTION

02231584	EPREX	JSO

3,000U/0.3ML SOLUTION

02231585	EPREX	JSO

4,000U/0.4ML SOLUTION

02231586	EPREX	JSO

5000U/0.5ML SOLUTION

02243400	EPREX	JSO

6000U/0.6ML SOLUTION

02243401	EPREX	JSO

8000U/0.8ML SOLUTION

02243403	EPREX	JSO

10,000/ML SOLUTION

02231587	EPREX	JSO

20,000U/0.5ML SOLUTION

02243239	EPREX	JSO

30,000U/0.75ML SOLUTION

02288680	EPREX	JSO

40,000U/ML SOLUTION

02240722	EPREX	JSO

PEGFILGRASTIM

10MG/ML SOLUTION

02249790	NEULASTA	AMG

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28:00 CENTRAL NERVOUS SYSTEM AGENTS

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

25MG CAPSULE

02402912	ACT PREGABALIN	ACG
02394235	APO-PREGABALIN	APX
02433869	AURO-PREGABALIN	AUR
02402556	DOM-PREGABALIN	DPC
02435977	JAMP-PREGABALIN	JMP
02268418	LYRICA	PFI
02417529	MAR-PREGABALIN	MAR
02423804	MINT-PREGABALIN	MIN
02382210	MYLAN-PREGABALIN	MYL
02359596	PMS-PREGABALIN	PMS
02396483	PREGABALIN	PDL
02403692	PREGABALIN	SIV
02405539	PREGABALIN	SAN
02392801	RAN-PREGABALIN	RBY
02377039	RIVA-PREGABALIN	RIV
02390817	SANDOZ PREGABALIN	SDZ
02361159	TEVA-PREGABALIN	TEV

50MG CAPSULE

02402920	ACT PREGABALIN	ACG
02394243	APO-PREGABALIN	APX
02433877	AURO-PREGABALIN	AUR
02402564	DOM-PREGABALIN	DPC
02435985	JAMP-PREGABALIN	JMP
02268426	LYRICA	PFI
02417537	MAR-PREGABALIN	MAR
02423812	MINT-PREGABALIN	MIN
02382229	MYLAN-PREGABALIN	MYL
02359618	PMS-PREGABALIN	PMS
02396505	PREGABALIN	PDL
02403706	PREGABALIN	SIV
02405547	PREGABALIN	SAN
02392828	RAN-PREGABALIN	RBY
02377047	RIVA-PREGABALIN	RIV
02390825	SANDOZ PREGABALIN	SDZ
02361175	TEVA-PREGABALIN	TEV

75MG CAPSULE

02402939	ACT PREGABALIN	ACG
02394251	APO-PREGABALIN	APX
02433885	AURO-PREGABALIN	AUR

28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

75MG CAPSULE

02402572	DOM-PREGABALIN	DPC
02435993	JAMP-PREGABALIN	JMP
02268434	LYRICA	PFI
02417545	MAR-PREGABALIN	MAR
02424185	MINT-PREGABALIN	MIN
02382237	MYLAN-PREGABALIN	MYL
02359626	PMS-PREGABALIN	PMS
02396513	PREGABALIN	PDL
02403714	PREGABALIN	SIV
02405555	PREGABALIN	SAN
02392836	RAN-PREGABALIN	RBY
02377055	RIVA-PREGABALIN	RIV
02390833	SANDOZ PREGABALIN	SDZ
02361183	TEVA-PREGABALIN	TEV

150MG CAPSULE

02402955	ACT PREGABALIN	ACG
02394278	APO-PREGABALIN	APX
02433907	AURO-PREGABALIN	AUR
02402580	DOM-PREGABALIN	DPC
02436000	JAMP-PREGABALIN	JMP
02268450	LYRICA	PFI
02417561	MAR-PREGABALIN	MAR
02424207	MINT-PREGABALIN	MIN
02382245	MYLAN-PREGABALIN	MYL
02359634	PMS-PREGABALIN	PMS
02396521	PREGABALIN	PDL
02403722	PREGABALIN	SIV
02405563	PREGABALIN	SAN
02392844	RAN-PREGABALIN	RBY
02377063	RIVA-PREGABALIN	RIV
02390841	SANDOZ PREGABALIN	SDZ
02361205	TEVA-PREGABALIN	TEV

300MG CAPSULE

02402998	ACT PREGABALIN	ACG
02394294	APO-PREGABALIN	APX
02436019	JAMP-PREGABALIN	JMP
02268485	LYRICA	PFI
02382253	MYLAN-PREGABALIN	MYL
02359642	PMS-PREGABALIN	PMS
02396548	PREGABALIN	PDL
02403730	PREGABALIN	SIV
02405598	PREGABALIN	SAN

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28:12.92 MISCELLANEOUS ANTICONVULSANTS

PREGABALIN

300MG CAPSULE

02392860	RAN-PREGABALIN	RBY
02377071	RIVA-PREGABALIN	RIV
02390868	SANDOZ PREGABALIN	SDZ
02361248	TEVA-PREGABALIN	TEV

52:00 EYE, EAR, NOSE AND THROAT (EENT)

52:28.00 EENT - MOUTHWASHES AND GARGLES

BENZYDAMINE HYDROCHLORIDE

0.15% MOUTHWASH

02239044	APO-BENZYDAMINE	APX
02229777	PHARIXIA	PED
02239537	PMS-BENZYDAMINE	PMS

52:92.00 MISCELLANEOUS EENT DRUGS

ARTIFICIAL SALIVA

0.05MG SPRAY

02238696	MOISTIR	PMS

56:00 GASTROINTESTINAL DRUGS

56:08.00 ANTIDIARRHEA AGENTS

DIPHENOXYLATE HYDROCHLORIDE, ATROPINE SULFATE

2.5MG & 0.025MG TABLET

00036323	LOMOTIL	PFI

56:22.32 MISCELLANEOUS ANTIEMETICS

APREPITANT

80MG CAPSULE

02298791	EMEND	FRS

125MG CAPSULE

02298805	EMEND	FRS

125MG & 80MG CAPSULE

02298813	EMEND TRI-PACK	FRS

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

0.25MG CAPSULE

02441497	APO-NABILONE	APX
02312263	CESAMET	VAE
02380897	PMS-NABILONE	PMS

56:22.92 MISCELLANEOUS ANTIEMETICS

NABILONE

0.25MG CAPSULE

02358077	RAN-NABILONE	RBY
02392925	TEVA-NABILONE	TEV

0.5MG CAPSULE

02393581	ACT NABILONE	ACG
02441500	APO-NABILONE	APX
02256193	CESAMET	VAE
02380900	PMS-NABILONE	PMS
02358085	RAN-NABILONE	RBY
02384884	TEVA-NABILONE	TEV

1MG CAPSULE

02393603	ACT NABILONE	ACG
02441519	APO-NABILONE	APX
00548375	CESAMET	VAE
02380919	PMS-NABILONE	PMS
02358093	RAN-NABILONE	RBY
02384892	TEVA-NABILONE	TEV

92:00 UNCLASSIFIED THERAPEUTIC AGENTS

92:24.00 BONE RESORPTION INHIBITORS

DENOSUMAB (XGEVA)

120MG/1.7ML SOLUTION

02368153	XGEVA	AMG

96:00 PHARMACEUTICAL AIDS

96:00.00 PHARMACEUTICAL AIDS

NUTRITIONAL SUPPLEMENT

ORAL LIQUID

09853154	BOOST FRUIT BEVERAGE	NES
95999970	BOOST HIPROTEIN	NES
95999963	BOOST ORIGINAL	NES
95999975	BOOST PLUS	NES
97904341	ENSURE	ABB
00801054	ENSURE HIGH PROTEIN	ABB
97904333	ENSURE PLUS	ABB
97904317	ENSURE WITH FIBRE	ABB

ACT NABILONE	3
ACT PREGABALIN	2
APO-BENZYDAMINE	3
APO-MINOCYCLINE	1
APO-NABILONE	3
APO-PREGABALIN	2
APREPITANT	**3**
ARANESP	1
ARTIFICIAL SALIVA	**3**
AURO-PREGABALIN	2
BENZYDAMINE HYDROCHLORIDE	**3**
BOOST FRUIT BEVERAGE	3
BOOST HIPROTEIN	3
BOOST ORIGINAL	3
BOOST PLUS	3
CESAMET	3
DARBEPOETIN ALFA	**1**
DENOSUMAB (XGEVA)	**3**
DIPHENOXYLATE HYDROCHLORIDE, ATROPINE SULFATE	**3**
DOM-MINOCYCLINE	1
DOM-PREGABALIN	2
EMEND	3
EMEND TRI-PACK	3
ENSURE	3
ENSURE HIGH PROTEIN	3
ENSURE PLUS	3
ENSURE WITH FIBRE	3
EPOETIN ALFA	**1**
EPREX	1
JAMP-PREGABALIN	2
LOMOTIL	3
LYRICA	2
MAR-PREGABALIN	2
MINOCYCLINE	1
MINOCYCLINE HYDROCHLORIDE	**1**
MINT-PREGABALIN	2
MOISTIR	3
MYLAN-MINOCYCLINE	1
MYLAN-PREGABALIN	2
NABILONE	**3**
NEULASTA	1
NUTRITIONAL SUPPLEMENT	**3**
PEGFILGRASTIM	**1**
PHARIXIA	3
PMS-BENZYDAMINE	3
PMS-MINOCYCLINE	1
PMS-NABILONE	3
PMS-PREGABALIN	2
PREGABALIN	**2**
PREGABALIN	2
RAN-NABILONE	3
RAN-PREGABALIN	2
RIVA-PREGABALIN	2
SANDOZ MINOCYCLINE	1
SANDOZ PREGABALIN	2
TEVA-MINOCYCLINE	1
TEVA-NABILONE	3
TEVA-PREGABALIN	2
XGEVA	3

APPENDIX E
EXTEMPORANEOUS MIXTURES

To be eligible under the NIHB Program, extemporaneous mixtures (compounds) must have at least one ingredient listed on the DBL and must not duplicate the formulation of commercially manufactured drug products. Mixtures that contain exception or limited use drugs must receive prior approval by the DEC. Mixtures that contain ingredients excluded from the Program will not be eligible for coverage.

All extemporaneous mixtures must be submitted with the corresponding pseudo-DIN to be reimbursed appropriately. Pharmaceutical powders of eligible ingredients may be used in lieu of tablets/capsules. These powders must be billed at AAC and must not exceed the maximum allowable AAC which is based on the price of the DIN of the comparable listed tablet or capsule.

Back Order Items and Compounding:
Providers who are preparing a compound to replace a commercially available product which is on back-order do not require a PA. The claim must be submitted using the corresponding miscellaneous pseudo-DIN. Providers are required to maintain documentation demonstrating that the commercially available product was on back-order at the time of dispense.

Compounds with Diclofenac:
Compounds with diclofenac as an ingredient require a PA and will be reviewed on a case-by-case basis

COMPOUNDED EXTERNAL LOTION

99502001	MENTHOL & CAMPHOR IN CORTICOSTEROID LOTION
99502002	MISCELLANEOUS COMPOUNDED EXTERNAL LOTION

COMPOUNDED EXTERNAL POWDER

99504000	MISCELLANEOUS COMPOUNDED EXTERNAL POWDER

COMPOUNDED EYE/EAR DROP

99507000	MISCELLANEOUS COMPOUNDED EYE/EAR DROP

COMPOUNDED INJECTION OR INFUSION

99506000	CEFAZOLIN STERILE INFUSION
99506001	CEFTRIAXONE STERILE INFUSION
99506003	PENICILLIN G STERILE INFUSION
99506004	GENTAMYCIN STERILE INFUSION
99506005	AMPICILLIN STERILE INFUSION
99506008	CLINDAMYCIN STERILE INFUSION
99506015	IRON SUCROSE STERILE INFUSION
99506021	MISCELLANEOUS COMPOUNDED INJECTION/INFUSION

COMPOUNDED INTERNAL POWDER

99505000	MISCELLANEOUS COMPOUNDED INTERNAL POWDER
99505003	PHENAZOPYRIDINE COMPOUNDED

COMPOUNDED INTERNAL USE LIQUID

99503000	HYDROCHLOROTHIAZIDE ORAL LIQUID
99503001	SPIRONOLACTONE ORAL LIQUID
99503002	OMEPRAZOLE ORAL LIQUID

COMPOUNDED INTERNAL USE LIQUID

99503003	AMLODIPINE ORAL LIQUID
99503004	NITRO-FURANTOIN ORAL LIQUID
99503005	DOMPERIDONE ORAL LIQUID
99503006	TRANEXAMIC DENTAL MOUTHWASH
99503007	DEXAMETHASONE ORAL LIQUID
99503008	PREDNISONE ORAL LIQUID
99503009	ALDACTAZIDE ORAL LIQUID
99503010	LANSOPRAZOLE ORAL LIQUID
99503011	BACLOFEN ORAL LIQUID
99503012	METRONIDAZOLE ORAL LIQUID
99503013	ENALAPRIL ORAL LIQUID
99503014	PROPRANOLOL ORAL LIQUID
99503015	METOPROLOL ORAL LIQUID
99503016	AMIODARONE ORAL LIQUID
99503017	TRIMETHOPRIM ORAL LIQUID
99503018	ALLOPURINOL ORAL LIQUID
99503019	AZATHIOPRINE ORAL LIQUID
99503020	BENZODIAZEPINE ORAL LIQUID
99503021	CLONIDINE ORAL LIQUID
99503022	RIFAMPIN ORAL LIQUID
99503023	SOTALOL ORAL LIQUID
99503024	UROSODIOL ORAL LIQUID
99503025	MISCELLANEOUS COMPOUNDED INTERNAL LIQUID
99503026	LEVETIRACETAM ORAL LIQUID
99503027	TOPIRAMATE ORAL LIQUID
99503028	ANTACID AND LIDOCAINE ORAL LIQUID
99503029	MAGIC MOUTHWASH
99503031	ISONIAZID ORAL LIQUID

COMPOUNDED SUPPOSITORY

99508000	MISCELLANEOUS COMPOUNDED SUPPOSITORY

COMPOUNDED TOPICAL CREAM

99500000	HYDROCORTISONE POWDER AND CLOTRIMAZOLE CREAM

To be eligible under the NIHB Program, extemporaneous mixtures (compounds) must have at least one ingredient listed on the DBL and must not duplicate the formulation of commercially manufactured drug products. Mixtures that contain exception or limited use drugs must receive prior approval by the DEC. Mixtures that contain ingredients excluded from the Program will not be eligible for coverage.

All extemporaneous mixtures must be submitted with the corresponding pseudo-DIN to be reimbursed appropriately. Pharmaceutical powders of eligible ingredients may be used in lieu of tablets/capsules. These powders must be billed at AAC and must not exceed the maximum allowable AAC which is based on the price of the DIN of the comparable listed tablet or capsule.

Back Order Items and Compounding:
Providers who are preparing a compound to replace a commercially available product which is on back-order do not require a PA. The claim must be submitted using the corresponding miscellaneous pseudo-DIN. Providers are required to maintain documentation demonstrating that the commercially available product was on back-order at the time of dispense.

Compounds with Diclofenac:
Compounds with diclofenac as an ingredient require a PA and will be reviewed on a case-by-case basis

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COMPOUNDED TOPICAL CREAM

99500001	STEROID AND ANTIFUNGAL CREAM
99500002	MENTHOL &/OR CAMPHOR IN STEROID
99500003	SALICYLIC ACID IN CORTICOSTEROID CREAM
99500004	MISCELLANEOUS COMPOUNDED TOPICAL CREAM
99500006	SULFUR IN NON-MEDICATED CREAM
99500008	MOMETASONE CREAM
99500009	LCD IN NON-MEDICATED CREAM
99500010	LCD IN CORTICOSTEROID CREAM

COMPOUNDED TOPICAL OINTMENT

99501000	LCD IN CORTICOSTEROID OINTMENT
99501001	SALICYLIC ACID IN NON-MEDICATED OINTMENT
99501002	SULFUR IN NON-MEDICATED OINTMENT
99501003	CALCIUM CHANNEL BLOCKER IN OINTMENT
99501004	MISCELLANEOUS COMPOUNDED TOPICAL OINTMENT
99501005	LCD IN NON-MEDICATED OINTMENT
99501006	ALL PURPOSE NIPPLE OINTMENT
99502000	CLINDAMYCIN IN DILUSOL OR DUONALC

STERILE EXTEMPORANEOUS MIXTURE

00915000	STERILE EXTEMPORANEOUS MIXTURE (QC)

APPENDIX F
LIST OF DRUG MANUFACTURERS

MFR	Manufacturer Name
AAP	AA PHARMA INCORPORATED
ABB	ABBOTT LABORATORIES LIMITED
ABV	ABBVIE CORPORATION
ACC	ACCORD HEALTHCARE INCORPORATED
ACG	ACTAVIS GROUP PTC EHF
ACN	ACTELION PHARMACEUTICALS LIMITED
ACP	ACCEL PHARMA INCORPORATED
ADA	ADAMS LABS LIMITED
ADD	AVEVA DRUG DELIVERY SYSTEMS INCORPORATED
ALC	ALCON CANADA INCORPORATED
ALK	ALK ABELLO A/S
ALL	ALLERGAN INCORPORATED
ALV	ALVEDA PHARMACEUTICALS INCORPORATED
AMG	AMGEN CANADA INCORPORATED
ANG	ANGITA PHARMA INCORPORATED
APC	APTALIS PHARMA CANADA ULC
APL	AUROBINDO PHARMA LIMITED
APU	ATNAHS PHARMA UK LIMITED
APX	APOTEX INCORPORATED
ARA	ARA PHARMACUETICALS INCORPORATED
ARI	ARIAD PHARMACEUTICALS INCORPORATED
ASP	ASPEN PHARMA TRADING LIMITED
AST	ASTELLAS PHARMA CANADA INCORPORATED
ATL	LABORATORIE ATLAS INCORPORATED
ATO	ATON PHARMA INCORPORATED, A DIVISION OF VALEANT PHARMACEUTICALS NORTH AMERICA LLC
AUC	AUTO CONTROL
AUP	AURIUM PHARMA INCORPORATED
AUR	AURO PHARMA INCORPORATED
AZC	ASTRAZENECA CANADA INCORPORATED
BAX	BAXTER CORPORATION
BAY	BAYER INCORPORATED, HEALTHCARE/DIAGNOSTICS
BDT	BECTON DICKINSON CANADA INCORPORATED
BEN	BENCARD ALLERGY LABORATORIES
BEX	BERLEX CANADA INCORPORATED
BGP	BGP PHARMA ULC
BMI	BIOMED 2002 INCORPORATED
BMS	BRISTOL-MYERS SQUIBB CANADA
BOE	BOEHRINGER INGELHEIM (CANADA) LIMITED
BSH	BAUSCH & LOMB CANADA INCORPORATED
BSY	BIOSYENT PHARMA INCORPORATED
BTD	WEB PACK INTERNATIONAL INCORPORATED
BTU	BRAINTREE LABORATORIES INCORPORATED
CHE	CHEPLAPHARM ARZNEIMITTEL GMBH GERMANY
CHU	CHURCH & DWIGHT CANADA CORP
CIP	CIPHER PHARMACEUTICALS INCORPORATED
CLC	COLUMBIA LABORATORIES CANADA INCORPORATED
COV	COVIDIEN CANADA
CPA	COLGATE-PALMOLIVE CANADA INCORPORATED
DCM	D & C MOBILITY
DDP	THE D DROPS COMPANY INCORPORATED

MFR	Manufacturer Name
DOR	DORMER LABORATORIES INCORPORATED
DPC	DOMINION PHARMACAL
DPI	DOMREX PHARMA INCORPORATED
DPT	DERMTEK PHARMA INCORPORATED
DUI	DUCHESNAY INCORPORATED
ECL	ECL PHARMA GROUP LIMITED
EIS	EISAI LIMITED
ELN	ELAN PHARMACEUTICALS INCORPORATED
ERF	ERFA CANADA INCORPORATED
ETH	ETHYPHARM INCORPORATED
EUR	EURO-PHARM INTERNATIONAL CANADA INCORPORATED
FEI	FERRING INCORPORATED
FKD	FRESENIUS KABI CANADA LIMITED
FMC	FRESENIUS MEDICAL CARE NORTH AMERICA
FRS	MERCK FROSST CANADA LIMITED
GAC	GALDERMA CANADA INCORPORATED
GEE	GENZYME CANADA INCORPORATED
GFP	GFR PHARMA LIMITED
GIL	GILEAD SCIENCES INCORPORATED
GLK	GLENMARK PHARMACEUTICALS CANADA INCORPORATED
GMP	GENERIC MEDICAL PARTNERS INCORPORATED
GPB	G POHL-BOSKAMP GMBH & CO KG
GSC	GELDA SCIENTIFIC & INDUSTRIAL DEVELOPMENT CORP
GSK	GLAXOSMITHKLINE INCORPORATED
HIL	HILL DERMACEUTICALS INCORPORATED
HJS	H.J. SUTTON INDUSTRIES LIMITED
HLR	HOFFMAN-LAROCHE LIMITED
HLS	HLS THERAPEUTICS INC
HOD	NIPRO DIAGNOSTICS CANADA LIMITED
HOS	HOSPIRA HEALTHCARE CORPORATION
HYD	HYDRATION PHARMACEUTICALS CANADA INCORPORATED
ICN	ICN CANADA LIMITED
IND	INDIVIOR UK LIMITED
INS	INSIGHT PHARMACEUTICALS LLC
IPS	IPSEN LIMITED
IVX	IVAX PHARMACEUTICALS INCORPORATED
JAC	JACOBUS PHARMACEUTICAL COMPANY INCORPORATED
JAJ	JOHNSON & JOHNSON
JAM	C.E. JAMIESON COMPANY LIMITED
JMP	JAMP PHARMA CORPORATION
JNO	JANSSEN-ORTHO INCORPORATED
JSO	JANSSEN INCORPORATED
JUB	JUBILANT HOLLISTERSTIER LLC
KAL	KALEO INCORPORATED
KIM	MCNEIL CONSUMER HEALTHCARE, A DIVISION OF JOHNSON & JOHNSON INCORPORATED
KLA	PATRIOT A DIVISION OF JANSSEN INCORPORATED
LAL	LABORATOIRE LALCO INCORPORATED
LAP	LABORATOIRE HRA PHARMA
LEO	LEO PHARMA INCORPORATED
LIL	ELI LILLY CANADA INCORPORATED

MFR	Manufacturer Name
LIP	LINEPHARMA INTERNATIONAL LIMITED
LUD	LUNDBECK CANADA INCORPORATED
LUI	LUITPOLD PHARMACEUTICALS INCORPORATED
LUK	LUNDBECK LLC
LUP	LUPIN PHARMA CANADA LIMITED
MAC	MACDONALD'S PRESCRIPTION LAB LIMITED
MAK	3M CANADA COMPANY
MAN	MANTRA PHARMA INCORPORATED
MAR	MARCAN PHARMACEUTICALS INCORPORATED
MAT	MALLINCKRODT CANADA ULC
MAY	MAYNE PHARMA (CANADA) INCORPORATED
MCA	MCARTHUR MEDICAL SALES INCORPORATED
MCL	MCNEIL CONSUMER PRODUCTS COMPANY
MDF	MEDICAL FUTURES INCORPORATED
MDS	MEDISCA PHARMACEUTIQUE INCORPORATED
MDT	MEDTRONIC OF CANADA LIMITED
MEC	MEDI+SURE CANADA INCORPORATED
MEZ	MERZ PHARMACEUTICALS GMBH
MIN	MINT PHARMACEUTICALS INCORPORATED
MJO	MEAD JOHNSON CANADA INCORPORATED
MPD	MEDICAL PLASTIC DEVICES INCORPORATED
MRL	MERUS LABS INTERNATIONAL INCORPORATED
MSF	MEDISAFE DISTRIBUTION INCORPORATED
MSL	MEDIC SAVOURE LIMITED
MTC	MEDTECH PRODUCTS INCORPORATED
MYL	MYLAN PHARMACEUTICALS ULC
NCA	NOVA DIABETES CARE
NEB	NEOBOURNE PHARMA LP
NES	NESTLÉ CANADA INCORPORATED
NOO	NOVO NORDISK CANADA INCORPORATED
NOP	NOVOPHARM LIMITED
NPH	NATCO PHARMA CANADA INCORPORATED
NUR	NUTRICORP INTERNATIONAL
NVC	NOVARTIS CONSUMER HEALTH CANADA INCORPORATED
NVR	NOVARTIS PHARMACEUTICALS CANADA INCORPORATED
OBT	COBALT PHARMACEUTICALS COMPANY
ODN	ODAN LABORATORIES LIMITED
OMG	OMEGA LABORATORIES LIMITED
OPU	OPUS PHARMA
ORM	ORIMED PHARMA INCORPORATED
OTS	OTSUKA PHARMACEUTICAL CORPORATION LIMITED
PAL	PALADIN LABS INCORPORATED
PDI	PROFESSIONAL DISPOSABLES INTERNATIONAL LIMITED
PDL	PRO DOC LIMITED
PED	PENDOPHARM INCORPORATED
PEI	PEDIAPHARM INCORPORATED
PER	PERRIGO INTERNATIONAL
PFI	PFIZER CANADA INCORPORATED
PFR	PURDUE PHARMA
PGI	PROCTOR & GAMBLE INCORPORATED
PHA	PHARMAPAR INCORPORATED
PMS	PHARMASCIENCE INCORPORATED

MFR	Manufacturer Name
PMT	PHARMETICS INCORPORATED
PPH	PAR PHARMACEUTICAL COMPANIES
PPI	PRESTIGE PHARMA INCORPORATED
RAX	STERIMAX INC
RBP	RB PHARMACEUTICALS LIMITED
RBW	R.W. PACKAGING LIMITED
RBY	RANBAXY PHARMACEUTICALS CANADA INCORPORATED
REC	DR REDDYS LABORATORIES INCORPORATED
RGL	RECRO GAINESVILLE LLC
RIT	THE RITEDOSE CORPORATION
RIV	LABORATORIE RIVA INCORPORATED
RLI	RED LEAF MEDICAL INCORPORATED
ROD	ROCHE DIAGNOSTICS
RPH	RATIOPHARM INCORPORATED
SAC	SANOFI-AVENTIS CANADA
SAN	SANIS HEALTH INCORPORATED
SDZ	SANDOZ CANADA INCORPORATED
SEA	SEARCHLIGHT PHARMA INCORPORATED
SEV	SERVIER CANADA INCORPORATED
SFA	HTL STREFA
SHI	SHIRE CANADA INCORPORATED
SHM	SHERWOOD INCORPORATED
SIV	SIVEM PHARMACEUTICALS ULC
SKY	LIFESCAN INCORPORATED, PART OF THE JOHNSON & JOHNSON
SLX	SALIX PHARMACEUTICALS INCORPORATED
SMW	SMITH & NEPHEW CANADA
SNE	SMITH & NEPHEW INCORPORATED
SPC	SUNOVION PHARMACEUTICALS CANADA INCORPORATED
SPH	SOLVAY PHARMA INCORPORATED
SPT	SEPTA PHARMACEUTICALS INCORPORATED
SRO	EMD SERONO A DIVISION OF EMD INCORPORATED CANADA
STE	STERIMAX INCORPORATED
STG	LABORATOIRES STERIGEN INCORPORATED
STI	STIEFEL CANADA INCORPORATED
SUS	SUNSTAR AMERICAS INCORPORATED
SWS	SWISS HERBAL REMEDIES LIMITED
TAK	TAKEDA PHARMACEUTICALS AMERICA INCORPORATED
TAN	TANTA PHARMACEUTICALS INCORPORATED
TAR	TARO PHARMACEUTICALS INCORPORATED
TEL	TELIGENT OU
TEV	TEVA CANADA LIMITED
TIL	TILLOTTS PHARMA GMBH
TIP	H & P INDUSTRIES / THE TRIAD-GROUP
TLI	LABORATOIRES TRIANON INCORPORATED
TPC	TRIBUTE PHARMACEUTICALS CANADA INCORPORATED
TPT	TAROPHARMA, A DIVISION OF TARO PHARMACEUTICALS INCORPORATED
TRE	TREMBLAY HARRISON INCORPORATED
TRI	TRIANON LABORATORIES INCORPORATED
TRM	ACERUS PHARMACEUTICALS CORPORATION
TRU	TRUDELL MEDICAL INTERNATIONAL

MFR	Manufacturer Name
TSN	TRIMEDIC SUPPLY NETWORK LIMITED
TYC	KENDALL HEALTHCARE
UCB	UBC PHARMA INCORPORATED
UMI	ULTIMED, INCORPORATED
UNK	
VAE	VALEANT CANADA LIMITED
VAN	VANC PHARMACEUTICALS INCORPORATED
VII	VIIV HEALTHCARE ULC
VTH	VITA HEALTH PRODUCTS INCORPORATED
WAC	WARNER CHILCOTT CANADA CORPORATION
WAM	WAMPOLE INCORPORATED
WEP	WE PHARMACEUTICALS
WNP	WN PHARMACEUTICALS LIMITED
WPC	WELLSPRING PHARMACEUTICAL CANADA CORPORATION
XED	XEDITON PHARMACEUTICALS INCORPORATED
XEN	XENEX LABS INCORPORATED

APPENDIX G
LIST OF EXCLUSIONS

Certain drug products are not within the scope of the program. These products will not be reimbursed as benefits under the NIHB Program:

Anti-obesity drugs;
Household products (regular soaps and shampoos);
Cosmetics;
Alternative therapies, including glucosamine and evening primrose oil;
Megavitamins;
Drugs with investigational/experimental status;
Vaccinations for travel indications;
Hair growth stimulants;
Fertility agents and impotence drugs;
Selected over-the-counter products;
Opioid containing cough preparations;
Dalmane®, Somnol® and generics (flurazepam);
Darvon® and 642® (propoxyphene);
Fiorinal®, Fiorinal® C ¼, Fiorinal® C ½ and generics (Butalbital containing analgesics with and without codeine);
Librium®, Solium®, Medilium® and generics (chlordiazepoxide);
Stadol TM NS and generics (butorphanol tartrate nasal spray);
Tranxene® and generics (clorazepate); and
Imovane® and generics (zopiclone).

The following drugs are excluded from the NIHB Program as recommended by the Common Drug Review (CDR) and the NIHB Drugs and Therapeutics Advisory Committee (DTAC) because published evidence does not support the clinical value or cost of the drug relative to existing therapies, or there is insufficient clinical evidence to support coverage.
Of Note: The Appeal Process and the Emergency Supply Policy will not apply for the following drug products.

DIN	MFR	Brand Name	Strength and Format
02248722	ALL	ACULAR LS	0.4% SOLUTION
02259052	AST	AMEVIVE	15MG/ML POWDER FOR SOLUTION
02247916	BAY	CIPRO XL	500MG TABLET (EXTENDED RELEASE)
02251787	BAY	CIPRO XL	1,000MG TABLET (EXTENDED RELEASE)
02248417	FEI	GYNAZOLE	2% CREAM
01926799	SAC	IMOVANE	7.5MG TABLET
02216167	SAC	IMOVANE	5MG TABLET
02244521	AZC	NEXIUM	20MG TABLET (DELAYED RELEASE)
02244522	AZC	NEXIUM	40MG TABLET (DELAYED RELEASE)
02241804	TAK	PANTOLOC	20MG TABLET (ENTERIC COATED)
02248503	GSK	PAXIL	12.5MG TABLET (EXTENDED RELEASE)
02248504	GSK	PAXIL	25MG TABLET (EXTENDED RELEASE)
02229437	FMC	PHOSLO	667MG TABLET
02256290	PFI	RELPAX	20MG TABLET
02256304	PFI	RELPAX	40MG TABLET

APPENDIX H
NEW LISTINGS

The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02434652	ACC	ACH-ESCITALOPRAM	10MG TABLET	2018-01-02
02434660	ACC	ACH-ESCITALOPRAM	20MG TABLET	2018-01-02
02461471	APX	APO-ASA LD	81MG TABLET (DELAYED RELEASE)	2017-10-24
02461889	APX	APO-ERLOTINIB	150MG TABLET	2017-11-01
02461870	APX	APO-ERLOTINIB	100MG TABLET	2017-11-01
02461862	APX	APO-ERLOTINIB	25MG TABLET	2017-11-01
02460912	APX	APO-PHENYTOIN SODIUM	100MG CAPSULE	2017-09-28
02451980	APX	APO-TENOFOVIR	300MG TABLET	2017-10-10
02466465	SAN	ATENOLOL	50MG TABLET	2018-01-02
02445905	SIV	ATOMOXETINE	18MG CAPSULE	2017-09-13
02436906	AUR	AURO-CLINDAMYCIN	150MG CAPSULE	2017-11-01
02459957	AUR	AURO-FLECAINIDE	50MG TABLET	2017-11-30
02459965	AUR	AURO-FLECAINIDE	100MG TABLET	2017-11-30
02460173	AUR	AURO-TENOFOVIR	300MG TABLET	2017-10-10
02455331	UNK	BRENZYS	50MG SOLUTION	2017-10-02
02455323	UNK	BRENZYS	50MG SOLUTION	2017-10-02
80076097	UNK	CALCIUM	500MG TABLET	2018-01-02
80066093	UNK	CALCIUM 500 VITAMINE D1000	500MG & 1,000IU TABLET	2017-10-24
80066082	UNK	CALCIUM 500 VITAMINE D400	500MG & 400IU TABLET	2017-10-24
80066089	UNK	CALCIUM 500 VITAMINE D400	500MG & 400IU TABLET	2017-10-24
02325632	RAX	CEFTRIAXONE SODIUM FOR BP	10G POWDER FOR SOLUTION	2017-11-23
02465574	UCB	CIMZIA	200MG SOLUTION	2017-11-28
02277778	UNK	CRITIC-AID CLEAR	71.5% OINTMENT	2017-10-16
80027592	OPU	DGEL	1,000IU CAPSULE	2017-11-01
02457393	LEO	ENSTILAR	50MCG & 0.5MG AEROSOL, FOAM	2017-12-01
02229293	TIL	ENTOCORT	3MG CAPSULE (SUSTAINED RELEASE)	2017-10-17
80003707	EUR	EURO-D	1,000IU CAPSULE	2018-01-01
02226030	NVC	EX-LAX CHOCOLATED	15MG TABLET	2017-09-12
02248307	GSK	FLONASE ALLERGY RELIEF	50MCG SPRAY	2017-10-10
00689785	SWS	HI POTENCY MAGNESIUM OXIDE	835MG TABLET	2017-12-20
02368072	VTH	IBUPROFEN	200MG TABLET	2017-11-16
09991094	MDS	ITRACONAZOLE PDR	POWDER	2017-09-13
80062704	JMP	JAMP POTASSIUM CHLORIDE ER	600MG CAPSULE	2017-11-16
80057178	JMP	JAMP-HC	1% CREAM	2018-01-02
02457881	JMP	JAMP-HYDRALAZINE	50MG TABLET	2017-11-02
02457873	JMP	JAMP-HYDRALAZINE	25MG TABLET	2017-09-20
02457865	JMP	JAMP-HYDRALAZINE	10MG TABLET	2017-09-20
80070358	JMP	JAMPLACTASE ENZYME	300MG TABLET	2017-10-24
02454319	JMP	JAMP-RISPERIDONE	1MG SOLUTION	2018-01-02
02465086	JMP	JAMP-RIZATRIPTAN ODT	5MG TABLET (ORALLY DISINTEGRATING)	2017-11-16
02465094	JMP	JAMP-RIZATRIPTAN ODT	10MG TABLET (ORALLY DISINTEGRATING)	2017-11-16
02450321	EIS	LENVIMA	10MG CAPSULE	2017-09-19
02450305	EIS	LENVIMA	20MG CAPSULE	2017-09-19
02450291	EIS	LENVIMA	24MG CAPSULE	2017-09-19
02450313	EIS	LENVIMA	14MG CAPSULE	2017-09-19
02432463	VAE	LODALIS	3.75G POWDER FOR SUSPENSION	2017-11-01
02409658	NVR	MEKINIST	2MG TABLET	2017-12-06
02409623	NVR	MEKINIST	0.5MG TABLET	2017-12-06
02320037	UNK	METOJECT	10MG SOLUTION	2018-01-10
02320029	UNK	METOJECT	7.5MG SOLUTION	2018-01-10
02320045	UNK	METOJECT	15MG SOLUTION	2018-01-10

The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02454858	UNK	METOJECT SUBCUTANEOUS	15MG SOLUTION	2018-01-10
02454750	UNK	METOJECT SUBCUTANEOUS	12.5MG SOLUTION	2018-01-10
02454769	UNK	METOJECT SUBCUTANEOUS	17.5MG SOLUTION	2018-01-10
02454777	UNK	METOJECT SUBCUTANEOUS	22.5MG SOLUTION	2018-01-10
02454866	UNK	METOJECT SUBCUTANEOUS	20MG SOLUTION	2018-01-10
02454874	UNK	METOJECT SUBCUTANEOUS	25MG SOLUTION	2018-01-10
02454823	UNK	METOJECT SUBCUTANEOUS	7.5MG SOLUTION	2018-01-10
02454831	UNK	METOJECT SUBCUTANEOUS	10MG SOLUTION	2018-01-10
80073689	MAN	M-HC UREA	1% LOTION	2017-09-20
80073645	MAN	M-HC UREA	1% CREAM	2017-09-20
02462192	MIN	MINT-CLONIDINE	0.1MG TABLET	2017-11-01
02462206	MIN	MINT-CLONIDINE	0.2MG TABLET	2017-11-01
02465167	MIN	MINT-FENOFIBRATE E	145MG TABLET	2018-01-02
99503033	UNK	MISC LIMITED USE COMPOUND INTERNAL	ORAL LIQUID	2017-12-29
99504001	UNK	MISC LIMITED USE EXTERNAL COMPOUND MIXTURE	MISCELLANEOUS	2017-12-29
02462974	PDL	MOXIFLOXACIN	400MG TABLET	2017-11-01
02461412	MYL	MYLAN-EFAVIRENZ/EMTRICITABINE/TENOFOVIR DISOPROXIL FUMARATE	600MG & 200MG & 300MG TABLET	2017-09-28
02382253	MYL	MYLAN-PREGABALIN	300MG CAPSULE	2017-11-01
02382229	MYL	MYLAN-PREGABALIN	50MG CAPSULE	2017-11-01
02382237	MYL	MYLAN-PREGABALIN	75MG CAPSULE	2017-11-01
02382210	MYL	MYLAN-PREGABALIN	25MG CAPSULE	2017-11-01
02382245	MYL	MYLAN-PREGABALIN	150MG CAPSULE	2017-11-01
02452634	MYL	MYLAN-TENOFOVIR DISOPROXIL	300MG TABLET	2017-10-10
02451883	UNK	NALTREXONE HYDROCHLORIDE	50MG TABLET	2017-09-20
02403935	UCB	NEUPRO	6MG PATCH	2017-10-23
02403900	UCB	NEUPRO	2MG PATCH	2017-10-23
02403943	UCB	NEUPRO	8MG PATCH	2017-10-23
02403927	UCB	NEUPRO	4MG PATCH	2017-10-23
99503032	UNK	OPIOID COMPOUNDED	ORAL LIQUID	2017-12-29
02466147	SAN	PANTOPRAZOLE T	40MG TABLET (DELAYED RELEASE)	2018-01-02
99505003	UNK	PHENAZOPYRIDINE COMPOUNDED	CAPSULE	2017-12-29
02305488	RIV	RIVA-FLUOXETINE	20MG CAPSULE	2017-11-01
02461994	SDZ	SANDOZ LEVETIRACETAM	500MG TABLET	2017-11-16
02461986	SDZ	SANDOZ LEVETIRACETAM	250MG TABLET	2017-11-16
02462001	SDZ	SANDOZ LEVETIRACETAM	750MG TABLET	2017-11-16
80064362	UNK	SENNA SENNOSIDES NATURALS	8.6MG TABLET (FILM COATED)	2017-10-24
80061813	VAN	SENNACE	43MG TABLET	2018-01-02
80054167	UNK	SENNOSIDES	15MG TABLET (FILM COATED)	2017-10-24
80072247	MDS	SODIUM BICARBONATE	325MG TABLET	2017-10-02
02409607	NVR	TAFINLAR	50MG CAPSULE	2017-12-06
02409615	NVR	TAFINLAR	75MG CAPSULE	2017-12-06
02464519	TAR	TARO-BENZOYL PEROXIDE / CLINDAMYCIN KIT	1% & 5% GEL	2017-09-28
02457504	TAR	TARO-CAPECITABINE	500MG TABLET	2017-11-16
02457490	TAR	TARO-CAPECITABINE	150MG TABLET	2017-11-16
02393549	TEV	TEVA-EFAVIRENZ/EMTRICITABINE/TENOFOVIR	600MG & 200MG & 300MG TABLET	2017-10-11

The following items have been added to the NIHB Drug Benefit List since it was last published. Some of these items may have specific criteria for use. Please consult Appendix A for criteria.

DIN	MFR	Brand Name	Strength and Dosage Form	Date Added
02403889	TEV	TEVA-TENOFOVIR	300MG TABLET	2017-10-10
02432420	VAN	VAN-FLUOXETINE	20MG CAPSULE	2017-11-16
02432412	VAN	VAN-FLUOXETINE	10MG CAPSULE	2017-11-16
02432625	VAN	VAN-MYCOPHENOLATE	500MG TABLET	2017-11-16
02433680	VAN	VAN-MYCOPHENOLATE	250MG CAPSULE	2017-11-16
02432404	VAN	VAN-OMEPRAZOLE	20MG TABLET (DELAYED RELEASE)	2017-11-16
02448440	VAN	VAN-ONDANSETRON	4MG TABLET	2017-11-16
02448467	VAN	VAN-ONDANSETRON	8MG TABLET	2017-11-16
02428520	VAN	VAN-RIZATRIPTAN	10MG TABLET	2017-11-16
02428512	VAN	VAN-RIZATRIPTAN	5MG TABLET	2017-11-16
02448505	VAN	VAN-RIZATRIPTAN ODT	10MG TABLET (ORALLY DISINTEGRATING)	2017-11-16
02438763	VAN	VAN-ZOLMITRIPTAN ODT	2.5MG TABLET (ORALLY DISINTEGRATING)	2017-11-16
80000131	VTH	VITAMIN D	1,000IU TABLET	2017-10-20

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